AMEND #5 PER INF G934 12/20/2012 JH
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #18 Per FH G923 1/06 2011 JH
State of Maryland Department of Health and Mental Hygiene

			1 - For State amend item Registrar	State of M 18 per fh	arylant g924	d'/Depa 2-9-12	tificate of	Health and Death	l Mental Hy	giene Reg. No	0.0	1 1	31.001
	D1		1. Decedent's Name (First, Middle, Last) 2. Date of Death									3. Time of Death	
	Physicia Medi		Dennis D. Goodma						Oct Month	<u> </u>	201 ^Y	ear	10:40 a M
	Examir	ner											
	Funeral		6517 Adak St. 5. Social Security Number 6.	Sex 1 M 2 G F	e (In yrs. las	st birthday)	Seat Pl	If Under 24 Hr		rth	rince		orges place (State or Foreign
704	Director		377 03 0320	14 M 2 □ F	95	Yrs.	Months Days	Hours Mir	037307	1916	5 5	out	n Carolina
	nd show	5	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Loc	ation					1	0d. Inside City Limits
	Maryla :8a-f s tiffed	rect	MD Prince (George's	Seat	t Plea	sant						1 Yes 2 No
	h the la or 2	al Di	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of Wha	at Coun	itry?
	ath wit	Funeral Director	6517 Adak Street	12. Was Decedent 8	Suprin II C	140.14	20743	lia ania O dala 0 d	2 16 - 17 11	USA			
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	è	11. Mantal Status 1 ☐ Never Married 2 ☐ Married 3 🔣 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 24 If Yes, Give Year or Dates.	No	lf	Vas Decedent of F Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)			Americ White, 6 Bla	etc.
15-	72 ho n "nat fedica	Completed	15. Decedent's (Specify only highest g		- 2	(Give k	ent's Usual Occup ind of work done	during most of we	orking	1	(ind of Busin		•
212	within rgiene. Ier thai		Elementary/Seconday (0-12)	College (1-4 or 5	i+)	Carpe) NOT use retired) nter			Offi		T P	rinting
Maryland	should be filed wand Mental Hyg rand Mental Hyg rs marked othe raumatic event,	To Be	17. Father's Name (First, Middle, Last) Silas Goodman					18. Mother's Na	ame (First, Middle,	Maiden		rey	
lary	should and M is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	g Address (Street	and Number or R	ural Route Numbe	er, City or	Town, State	e, Zip C	Code)
	and 2 s Health tem 27		Brenda Turner/Dau 20a. Method of Disposition	ghter				eet Seat	Pleasan	t, M	1D 207	43	
Baltimore,	0		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cer	metery, crem Linc		tery 10/	Date 13/2011	Bren		, M	D
Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licer	rederie	11)				arshall- Suitlan				I Home
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Acute Myocardial Infarction									Approximate Interval Between			
200										Onset and Death			
-	Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):										
	scuted and transit	xam	Cause (Disease or linjury that initiated events c										
_	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a	conseque	ence ory:							
				d									
Box 68	To the Hospital or Attending Physician: The law requires that the death certifics within 24 harous after death. Within 24 harous after death. Within 24 harous after death. Completed filled in by the funeral director, page 2 should be detached for use as it is a solution.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 Fetal o	death 3 🗌	Ectopic pregnand Other (specify)	y -			23d. Date of Month		ery Day Year
P.O.	s that t gned b	by P	Part II. Other significant conditions		ut not result	ting in the un	derlying cause giv	en in Part I.	23e. Did to	obacco ı	use contribu	te to th	e cause of death?
rds,	requires been sig should b	ted	Diabetes Mellit	ıs					1 🗆	Yes 2	No 3	☐ Prob	ably 4 Unknown
Division of Vital Records,	The law nate has b	Completed	Hyperlipidemia							prior to completion of cause of death?			
ital	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital;				ace of Death (Che					
of V	g Physer this eral di	e: 10	1 ☐ Yes 2 D No 27. Manna of Death	28a. Date of injur	y 2	R/Outpatient 8b. Time of	3 DOA Othe	4 L Nursing	Home 5 Resid			Specify)	
ono	ending eath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigatio		Year)	injury	work	? Yes 2 □ No	Zod. Boosiiso i	iow injur	y cocarroa		
Divisi	tal or Att	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	ry - At hom (Specify)	e, farm, stree	et, factory, office		28f, Location (S City or Tow			r Rural	Route Number,
	To the Mospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 □ Medical Exam	sician: To the best of n iner: On the basis of ex se Practioner: To the b	amination a	and/or investic	ation, in my opinic	 n. death occurred 	at the time, date a	ind place	and due to	the cau	se(s) and manner stated.
	To the within comple		29b. Signature and title of certifier	co e	2		29c. License		10		te signed (M		
	W.		30. Name and address of person who	completed cause of de	ath (frem a	Sa) (Type, Pri	PU STORY	200	hour	7m	Md	7 6	56
•	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registrar	's Signatur	Ked .							

			Please	Type or Pri						-		_	le.	
			ForState	State of M	aryland					Mental Hy	/gien	e 201	1	21002
			Registrar 1. Decedent's Name (First, Middle, Las	<i>t</i>)	_	Cer	tifica	te of L	Jeath	2. Date of D	Reg. N	lo.		34002
	Physicia		John Frederick H	•						Octobe:		To 201	a	3. Time of Death 6:50 a M
me	Medi Examir		4a. Facility Name (if not institution, give	street and number)			4b. City	, Town, or	Location of Deat		$\overline{}$	c. County of		
-	<i>Y</i>		Vantage House					Colum			Howard			
	Funeral Director		5. Social Security Number 6. Sec. 098-05-6470 1. Usual Residence of Decedent	7. Ag	e (In <i>yrs. la</i> s	t birthday) Yrs.	If Unde Months	er 1 Year Days	If Under 24 Hrs Hours Min.			23	Birthp Count	place (State or Foreign try) NY
	show dat	5	10a. State 10b. County		10c. City,	Town or Loc	cation						1	0d. Inside City Limits
	Maryla 28a-f	irect	MD Howard	đ		Col	umbi	.a						1 🗌 Yes 2 🙀 No
	th with the Maryland ms 23a or 28a-f sho must be notified at	Funeral Director	10e. Street and Number	- L D- 3			10f. Zi	ip Code				Citizen of Wha		
	ath wi	nuel	5400 Vantage Poi	12. Was Decedent I	ver in IIS	13 V	Nas Dece	210	44 spanic Origin? (S	necify Yes or No		United		
36	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🌣 Widowed 4 ☐ Divorced	Armed Forces? 1 K Yes 2 If Yes, Give	704	12- "	f Yes, spe	ecify Cuba	n, Mexican, Puerl Specify:	to Rican, etc.)		14. Race - A Black, N Specify:	Vhite, e	etc.
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Σ	id 2 sh alth a n 27 is er tra		Laura Sheely - Da	aughter					ern Rida					
ore	e 1 an of He If item		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Pla	ce of Dispo	sition (Na	me of		Date		Location - Cit		
Baltimore,	t. Page tment c tant: If jury or		4 Donation 5 Other (Specify		Ar	dent	Crem	ator	7 10/	11/2011		lanover	•	
Bal	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Funeral Service License	~ - Wh.	the	22	. Name a	nd Addres	ss of Facility Ha	rry H. V	Vitz	ke's F	ami tu	ly F.H.Inc. MD 21043
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused	the death.							OCC CI	و لايا	Approximate
	Ph_sician/		Immediate Cause (Final disease or condition	Conges		Heart	Fai	lure						Interval Between Onset and Death
Ų.	Medical Examiner	Ш	resulting in death)	Due to (or as:	a consequer	nce of):								· · · · · · ·
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63	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	210 10 101 20	a control	10000								
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687	certific iding p	M/C	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	ev.						23d. Date o	f dolive	
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal of time of dea	death 3 ath 5	Ectopic Other (s	pregnanc pecify)	у			Month	i delive	Day Year
s, P.O.	ires that t signed b Id be deta	d by P	Part II. Other significant conditions co	ntributing to death b	ut not result	ing in the u	nderlying	cause giv	en in Part I.					ne cause of death?
Division of Vital Records,	law requ has beer je 2 shou	mplete								24a. Was	yago	24b. Wer prio dea	e autor r to coi	osy findings available mpletion of cause of
Ä	in: The ifficate or, pag	ပိ	25. Was case referred to medical					26 DI	ace of Death (Che	perf	2 X	No 1		2 No
Vita	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 X] No	lospital:	ent 2 🗆 EF	R/Outpatien	t 3 🗆 D	Othe))	Home 5 🗆 Res	idence	6 Other (S	Specify)
on of	nding Ph ath. :: After th e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Day	ry 28	Bb. Time of injury		28c. Injury work	at	28d. Describe			,	
ivisio	l or Atter after dea Director	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc		e, farm, stre	et, factor	y, office		28f. Location City or To			r Rural	Route Number,
	Hospita 24 hours Funeral eted filler	Medical		fer: On the basis of e	xamination a	nd/or investi	igation, in	my opinio	n, death occurred	at the time, date	and place	ce, and due to	the cau	use(s) and manner stated.
	To the within To the Comp		only one) 3 Certifying Nyrs 29b. Signature and title of certifier	e Practioner: 10 the	best of my k	nowleage, a		c. License		ace, and due to t		ate signed (N		
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	ot		30. Name and address of person who co	poleted cause of d	eath (Item 2									
1	Stat		Andy Lazris MD 31. Date filed (Month, Day, Year) 0CT 122	22 Digistro					, MD 2.	1044				
	Registra	ir	OCT 12 2	1 Person	~ /	- 19	for an							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 6:40 A October Clytee Cunningham Hester Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours **Director** 1 □ M 2 😾 F 578-16-8647 97 Usual Residence of Deceden August 28,1914 Tupelo, MS or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 20902 11620 Kemp Mill Road United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: African-American "natural", 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Dietary Worker Hospita1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental H

27 is marked of
traumatic ever မ Samuel Cunningham Beatrice unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st tment of Health a tant; If item 27 is jury or other trai Diane T. Saulsbury, Niece 4208 31st Street, Mount Ranier, Maryland 20712-1732 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State Department of Important; If any injury or 4 Donation 5 Other (Specify) Fort Lincoln Crematory 10/17/2011 Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ a Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Atrial Fibrillation that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death been signed by the a should be detached i q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? after death.

Director: After this certificate | 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospita Other: 1 Yes 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending iniury work?
1 Yes 2 No filled in by the Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number October 1, 2011 D6593

Registrar

DHMH 17 Rev 06-2011

State

Backs

8714 Georgia Avenue, Silver Spring, Maryland 20910

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Onukogu,

Adaku Chimtua

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Month Year PS-Martin 807M Medical Facility Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County -County of Death Burnie Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F eor. 2 Months Min. **Director** items 23a or 28a-f show her must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No 10e, Street and Numb 10f. Zip Code 10g. Citizen of What Country? Funeral IJ.S.A 20155 . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Examiner 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. ō Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2' No 1 ☐ Yes 2 X No Specify: "natural". If Yes, Give Completed Specify: White 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry e 1 and 2 should be filed within 72 k t of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Medi (Specify only highest grade completed) (Give kind of work done during most of working DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) omemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Holmes Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1846 CHN CINCLES, Fort Neadl, MD Department of Health ar Important: If item 27 is any injury or other trau xxdsontorand d Aughter 20a. Method of Disposition 200. Place of Disposition (Name of Page 1 g 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State crematory or other Triangle, VA Quantico National 10/18/2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 10719 Courthouse Red ons M01080 - FBurg VA 22407 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ HRONIC MLMONARY disease or condition resulting in death) 015 Medical Due to (or as a consequence of): Examiner JES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed: death? certificate 2 🗌 No Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work Accident Suicide Investigation 1 \square Yes 2 🗆 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Fune

completed file 29a. Certifier (Check To the P only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) State 32. Registrar's Signature Venue Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | 34005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October Physician/ 9:00 AM 2011 Hardee F. Harrell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7901 Laurel Lake Ct. Laurel Prince George's 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F Feb. 17, 1919 Washington D.C. **Director** 578-07-3307 92 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 No Md. Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7901 Laurel Lake Ct. 20707 U.S.A. items death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, ō 1 Never Married 2 K Married ģ 1 ★ Yes 2 No within 72 hours after 3 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Page 1 and 2 should be filed within 72 hours aften ant of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", Completed 3 Divorced 4 Divorced White Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Ice Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hardee F. Harrell Lena Follin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hardee L. Harrell (Son) 1601 Argonne Pl. N.W. #505 Washington D.C. 20009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Washington Nat'l.Cem. 10/13/11 Suitland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chambers Funeral Home & Crematorium, P.A. Riverdale. Md. 20737 Thomas (hams 5801 Cleveland Ave. Riverdale, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ cardiamyo disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consumence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-thanks. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by melanoma 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, FACC 14 1450 mercantile Lane, STE. 217, Largo, MD 20174

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 11:14 Herrino 2011 10 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death **Examiner** Himore Baltimore 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** nth, Day, Delaware Director Usual Residence of De 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe o ems 23a or r must be r Funeral 993 tems Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. "natural", or iter ledical Examiner r 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates. 1978-1980 3 Divorced Health and Mental Hygiene. tem 27 is marked other than "natul other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) onday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide ပ 19a. Informant's Name/Reactionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau once, - City or Town, State Date 20c. Location 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation 19933 21. Signature of Fy ral Service License BridgeolleDE 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A proximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hepatitis disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant Pregnant at time of death Yes been signed by the should be detached g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed? Yes 2 X N his certificate his director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💢 No 9 1 🖊 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending hours after death. neral Director: After a filled in by the fun 1 Tes 2 🗌 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

TE State

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29b. Signature and title of certifie

30. Name and aux

Ryan Sangle, M

Pate filed (Monta) Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

6 2011

Registrar

29d. Date signed (Month, Day, Year)

2011

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BaltimoreMO 2120

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Bonnie Ree Hammond Medical 011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death comico **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Davs Hours Min 219-03-1760 89 Director North Carolina Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico 1 X Yes 2 No Salisbury 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? by Funeral 1705 East Gate Drive, Apt 202 21804 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. permit, Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or i any injury or other traumatic avens the status. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Gift Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ James M. McCann Maude Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Melvin/daughter 119 Waldon Dr., Fruitland, MD 21826 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/12/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signa Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ DIOMYOPA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes DNo
9 Unknown Pregnant at time of death Month Day Year signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Ves 2 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner' Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending after death. Accident Investigation 1 Yes 2 No the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated d title of certifier 29b. Signature a 1178 2666 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O SDay Physician/ Month O Medical Howard 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico 8. Date of Birth (Month, Day, Year 6-7-1920 If Under 1 Year If Under **Funeral** Age (In yrs. last birthday) 24 Hrs. 9. Birthplace (State or Foreign 1 X M 2 - F Days Hours Country)
Delaware Director 220-01-7175 91 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Wicomico Salisbury ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 611 Tressler Drive. 21801 Room 209 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department for Health and Mental Hygiene. Important: If the 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Owner/Operator Rental Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Herman Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph H. Howard - Son 26270 Mt. Vernon Road, Princess Anne, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 🗖 Donation 5 🗌 Other (Specify) Wicomico Memorial Pk. 10-10-2011 Salisbury, Maryland 21. Signature of Fundal Service License 22. Name and Address of Facility Bounds Funeral Home E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ CHRONIC OBS ULMONAR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leaving to immediate cause. Enter Underlying Due to (or as a consequence of). Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atte in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 ☐ Unknown 1 Yes 2 No Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA PICIZ 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury Natural 5 Pending injury work?
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Registrar

Date filed (Month, Day,

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DHMH 17 Rev 1/2001

		For State Registrar		Maryland		artment of H rtificate of I		Re	eg. No	34010			
Physicia /Medic	al	Decedent's Name (First, Midd Jeraldi: 4a. Facility Name (If not institution)	ne M. Hall	abor)		Ab City Town or		2. Date of Death Month Septembe	Day Year 29, 2011				
Funeral Director	_4	South River Rehabilitation				birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Anne A		Arunde1 thplace (State or Foreign ountry) DC			
Maryland I-f show fled at	tor	Usual Residence of Decedent 10a. State 10b, County DC	/		Town or Lo		Vashingto		, 1,1,1	10d. Inside City Limits 1 🖾 Yes 2 🗆 No			
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only higher Elementary/Secondary (0-12) 12th	nt's Education est grade completed) College (1	-4or 5+)	(Give life.	dent's Usual Occup kind of work done of NOT use retired ical Reco	during most of work f) rds Techr	nician	16b. Kind of Business Govern:	-			
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permit. Pa Departmer Important any Injury once.		4 □ Donation 5 □ Other (. 21. Signature of Funeral Service	* **	wart	= 0 22		ss of Facility St		Clinton, neral Home hington, D				
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To the Hospital To the Funeral I Completely filled	Medical	(Check only one) 2 ☐ Medica (Check one) 2 ☐ Me		asis of examinationer stated.	on and/or in	29c. Licens	e number		29d. Date signed (Mo				
eQ. Star		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIRE BENNETT CRNP HH WASHNUTON RD EDGWATER MD 21037 31. Date filed (Mogth_Day, Year) 32. Registrar's Signature.											

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Pt	1	_	ontributing to death bu			nderlying cause gi	en in Part I.	23e. Did to	obacco u	ise contrib	oute to the	e cause of death?
sen siç ould b	ted		•	TENS:					1 📗	Yes 2	⊠ No 3	Proba	ably 4 🗆 Unknown
has b	Completed	ATR	IAL	FIBA	RIL	LAT	ION		24a. Was autor	osy	pri	ior to con	sy findings available pletion of cause of
icate r, pag		05 NV	· · · · · · ·	··					perfo	rmed? 2 No		ath?	2 □ No
certil	m	25. Was case referred examiner? 1 \sum Yes 2		Hospital:			Oth	ace of Death (Che	2				
er this eral d	e: 10	27. Manner of Death	110	28a. Date of injur	y	ER/Outpatier 28b. Time of	t 3 DOA 28c, Injury	4 ☐ Nursing H	dome 5 Resid				
sath.	licat	1 Natural 2 Accident	5 Pending Investigation		Year)	injury	work			o (, 000000		
ifter d irect	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injurbuilding, etc.		ne, farm, stre	eet, factory, office		28f. Location (S City or Tow			or Rural F	Route Number,
ours a		29a. Certifier 1	Continue Phys	laine. To the best of		. I I. all .							
iin 24 F he Fur	Medical	(Check 2 L		ician: To the best of r ner: On the basis of ex e Practioner: To the b	amination	and/or invest	igation, in my opinic	n, death occurred a	at the time, date a	nd place.	and due to	o the caus	se(s) and manner stated.
To t		29b. Signature and tit	le of certifier	gandle			29c. License	number		29d, Dat	e signed (Month. Di	av. Year)
2		- V , ?		()			DOI	0260	64		10-1	04.	-2011
36	- 1	VIDYASI	AGAR -	ompleted cause of de	IAN	DLA	rint) 105	83- TH	TEO DOF	RE	GR	EEI	-2011 VBLVD -0695
State Registra	e r	31. Date filed (Month,	CT 0 6 20	22 Bagistra	r's Signatu	1. Apa	ake	,	9)	<u> </u>		
				. / /									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death RAMONA JEAN KEENAN 16:47 2011 10 08 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death GOOD SAMARITAN HUSPITAL BALTIMORE Baltimore City MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2√X 47 222-40-4711 12/28/1963 Trenton, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits New Castle Townsend 1XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Main Street 19734 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LPN Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard A. Schmitt, Sr. Maryann Ponting 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Paul Keenan/Husband P. O. Box 205, Townsend, DE 19734-0205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State Metro Crematory 10/15/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad St., Middletown, DE 19709 23a. Part 1. Enter the disease, younglications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death UROSEPSIS disease or condition resulting in death) DAYS Due to (or as a consequence of): DAYS ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): YEARS MORBID OBESITY Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 11 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐Yes 2 ☑No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f sh Examinar must be contilled

the Medical

and Mental Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other t any Injury or other traumatic event, In-once.

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

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EENAN

Director

by Funeral

Completed

Be

2

attending physician and for use as the burial-trar

certificate has been signed by the rector, page 2 should be detached : After this certification funeral director, f

requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, e Hospital or Attending P 24 hours after death. e Funeral Director: After ti letely filled in by the funera

To the Hospital within 24 hours a To the Funeral I completely filled

State Registrar

5

Physician/Medical 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 HYPOTHYROIDISM OBSTRUCTIVE SLEEP APNEA Completed PHLMONARY Be 25. Was case referred to medical 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated

29c. License number

RESOUD

29d. Date signed (Month, Day, Year)

10/08/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE

DR MA AI THANDA HAN .MD ,

MD.

29b. Signature and title of certifier

Thanda

31. Date filed (Month, Day, Year) 32. Régistrar's Signature 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Otente. 5, 200/11 Kostakos Physician/ Catherine Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Sunrise of Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 3 (49 12 9 19 19 7 NewntryJersey Months Days Hours Min. 1 □ M 2 🔼 F 153-12-6740 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State at Director 1 ☐ Yes 2 🖺 No notified Silver Spring Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 20906 10e. Street and Number ō USA "natural", or items 23a or 3278 Gleneagles Drive #20 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Nas Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 K No Specify: Specify 3 - Widowed 4 - Divorced Completed Year or Dates traumatic event, the Medical 16b. Kind of Business Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired)

Homemaker Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 18. Mother's Name (First, Middle, Maiden Sur Angelina Eftaxas Be 17. Father's Name (First, Middle, Last) Louis Pappas ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, Md 2789 Autumn Chase Road Deborah Kostakos/Dau.-in-law other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a Department of It Important: If ite any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Colesville Cem. Colesville, Md 10/07/201 4 Donation 5 Other (Specif PHALTBADERINALDI FUNERAL SERVICE, P. A. 9241 Columbia Blvd. Silver Spring, Md20910 21. Signature of Funeral Service Liver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Dysphagia Physician/ Due to (or as a consequence of) Medical resulting in death) of cerebral vascular accidents **Examiner** Late effects Sequentially list conditions, if any, leading to immediate Due to or as a consequence of Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the burialphysician Completed by Physician/Medical Box 68760 use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? Day Year Month jo Pregnant at time of death been signed by the should be detached g | Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. gait disturbance, history of recurrent falls, 1 Tes 2 No 3 Probably 4 Unknown Records. fall with right hip fracture surgery declined 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s performed? Yes 2 XN 2 🗌 No 1 Tyes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Hospital or Attending Physician; æ examiner?
1 Yes Other: 4 \sum Nursing Home Hospital: 6 A Other (Specify) 5 Residence Certificate: To 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28d Describe how injury coursed chair in stood up from chair in bedroom and fell to floor 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 9 /26/2011 5 \square Pending 3 : "O'O pm. 1 Natural
2 Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office \$1570 Hampshize904e. determined Suntise of Silver Spring Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title D35579 10/06/2011 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Susan Miller MD 8218 Wisconsin Ave #305 Bethesda, Md 20814

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

1 1 2011

barked

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Ρ OCTOBER 2011 2:05 ELDA WANDA KREAMER 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) ITALY 07/07/1920 Days Hours 1 M 2 X 91 Yrs **Director** 169-14-3022 Usual Residence of Decedent 28a-f show 10d, Inside City Limits aţ 10a, State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director Examiner must be notified 1 Tes 2 X No MD OUEEN ANNE'S STEVENSVILLE 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 313 KEENE FARM LANE 21666 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. Specify: WHITE 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) College (1-4 or 5+) FEDERAL GOVERNMENT 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BENITO ROSATI SANTINA NERI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS KREAMER / SON 313 KEENE FARM LANE, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ESAPEAKE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State CH 10/11/2011 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funer ice Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL 106 SHAMROCK ROAD, CHESTER, MD 21619 HOME, P.A. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, such line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ 10 Card disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to for as a consequence of) if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown sate has been signed by the page 2 should be detached g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 No 1 🗆 Yes 2 🐼 1 🗆 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work within 24 hours after death.

To the Funeral Director: Al 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 D0062964 dress of person who completed cause of death (Item 23a) (Type, Print) Play Suite Suo Annapolis MD 21401

Registrar DHMH 17 Rev 7/2009

State

renc

31. Date filed

God Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34015 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 0873 NDA 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Month, Day, Your Ch Months Days Hours Min Country) Sparta 413-56-1770 Director 75 936 March Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 🗆 Yes 2 🔀 No Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5720 Brooks Woods Road 20711 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗵 No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eddie Wilburn Copeland Ova Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred Ray Keir, Jr. / Husband 5720 Brooks Woods Road, Lothian, MD 20711 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/12/2011 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 lan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ TROKE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law equires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 No the 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy abed a certificat 1 Yes 2 No ☐ Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \(\text{Yes} \quad 2 \(\text{No} \) iniury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a

To the Funeral E

completed filled Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce**n**ifier 29c. License number Date signed (Month, Day, Year) 01

State Registrar 31. Date filed (Month, Day

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1

NTA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 6:45A M 10 2011 Jackie Lyons Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre De Grace 210 Alliance Street Harford 8. Date of Birth (Month, Day, Year) 2–19–1934 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Min. 1 🕱 M 2 🗆 F Hours Director WV 235**-**56-1748 Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland at Hygiene do duter than "natural", or items 23a or 28a-f sho dother than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Havre De Grace MD Harford 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 210 Alliance Street 21078 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ed Forces? Black, White, etc. Armed Forces: 1 X Yes 2 No If Yes, Give Year or Dates. <u></u> 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H မ Dewey Meadows Vera Agnes Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra Jackie Lyons, Jr. - son 210 Alliance Street, Havre De Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Mem. Gardens: 10/15/2011 Aberdeen, MD 22. Name and Address of Facility R.T.Foard Funeral Home, PA 21. Signature of Funeral Service Licenses 111 S. Queen Street, Rising Sun, MD 21911 231 art 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one leave on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Enetastati Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or ilinjury that initiated events Due to (or as a consequence of): Exami be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Box 68760 P.O. Records, Hospital or Attending Physician: Division of Vital

Baltimore, Maryland 21215-0036

To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral to

Certificate:

Medical

State Registrar

31. Date filed (Month, Day, Year)

5 Pending

Investigation 6 Could not be

determined

27. Manner of Death

1 Natural

Accident

29b. Signature and title of certifier

Suicide

4 Homicide

(Check only one

30. Name and address of person who compreded cause of death (Item 23a) (Type, Print) hesapeake Drive #409, Bel Air, MD 21014 510 U Mer C 32. Registrar's Signature

28a. Date of injury (Month, Day, Year)

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

2 No

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

October 12th 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 201 T Nancy LaCouture 2:54 P. M Lee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral Director** 217-44-2643 1 M 2 X F 02/16/1945 66 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2X No Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 1st Street 20711 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) school bus driver transportation company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Markev Bel1 Edith Collins Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20714Mark A. LaCouture, son Street, P.O. Box 441, North Beach, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. Metropolitan Crematory 10/08/11 Alexandria, VA Signa of Funeral Service Licen 22. Name and Address of Facility Rausch Funeral Home, P.A. <u>Harmony Lane, Owings, MD</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition SEPSIS Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner WFECTED -6865 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached t 9 Unknow 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pm, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 2 Hospital Other: 1 🗌 Yes မှ patient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr Postel medical 31. Date filed (Month, Day, Year, 32. Registra s Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2011 Virginia Victoria Lyons 6:25 p October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester Chesapeake Woods Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Sept. 10, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year Months 1 □ M 2 1 F 91 1920 Maryland Director 216-14-2279 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f shov the Medical Examiner must be notified at Dorchester 1 X Yes 2 ☐ No Completed by Funeral Director Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 Glenburn Avenue USA 21613 permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a, any injury or other traumatic event Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Baltimore, Maryland 21215-0036 🧪 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: white Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) seamstress garment mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James H. Warst Apalonia Hooper ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Estelle Gore daughter 714 Peachblossom Ave., Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 10/10/11 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or re-piratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 1 ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Hursing Home Hospital: 1 ☐ Yes 2 🔀 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🗆 Yes 2 🗆 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number certifier completed cause of death (Item 23a) (Type, Print 30. Name and address of person who

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State Registrar 31. Date Hed (Month

1V4 (1

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jeanne Scott October 2011 9:52 Medical ам 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Bedford Court Nursing Home Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Yes) 9. Birthplace (State or Foreign Country)

KY 1 M 2 XF Months Hours Director 402-22-3699 88 Sept. Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Silver Spring 1 Yes 2 No Montgomery 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 15100 Interlachen Drive, #315 20906 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces? 0 Black, White, etc. 1 Never Married 2 Married within 72 hours after Completed by Baltimore, Maryland 21215-0036 Specify.White If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural" 3 Widowed 4 N Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Scott Florence Sherrard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Lee/Son 14219 Woodcrest Drive, Rockville, MD 20853 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 10. 20c. Location - City or Town, State 2 1 Durial 2 Crem State injury o 4 Donatis Other (Specify) Metropolitan Crematory 2011 Alexandria, VA / icense Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician/ Immediate Cause (Final Onset and Death Metastatic Adenocarcinoma of Lung disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Band To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No 3 Ectopic pregnancy
5 Other (specify) Month Day Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has performed? Yes 2 No To Be funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury Accident
Suicide 1 🗌 Yes 2 No filled in by the Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

within 2

12

29a. Certifier (Check

Signature and title of certifie

Bindu Joseph,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

DHMH 17 Rev 7/2009

State Registrar Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1355 Piccard Drive, Rockville, MD 20850

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

October 8, 2011

29c License number

D60634

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 Physician/ 10:30 A Dorethea Tnez Lancaster october 7, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** (Month, Day, Year, Days Hours 578-44-1855 **Director** 1 🗆 M 2 🔀 F 89 Feb. 24 1922 D.C. show 10d. Inside City Limits iral", or items 23a or 28a-f shore Examiner must be notified at 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Forestville 1 X Yes 2 No MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 U.S. 6521 Hil-Mar Dr., #403 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 X No Specify. "natural" 3 Widowed 4X Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Healthcare Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Isabelle Lewis Matthew Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Althea Saunders - Daughter 6521 Hil-Mar Dr., Forestville, MD 20747 f Health Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Oct. 18 2011 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Pk Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bornette & Assoc. Funeral Home 2504 28th St., N.E., WDC 20018 23a Part 1. Inter the dispass, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transi attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 No 1 Yes the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 - No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 ☐ Yes 2 ☐ No efter decth. Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check hy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Prectiti

State Registrar Name and address of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 11, 2011 3:16 P M Mallard Frances L. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Village at Harbor Pointe South Salisbury Wicomico 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 🗆 M 2 😾 F Washington, DC Director 212-20-6198 06/26/1924 87 ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Worcester MD Pines Ocean 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral United States 21811 9 Moonshell Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? Black, White, etc 0 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White "natural", Completed 3 ₩ Widowed 4 □ Divorced Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. ther than "n. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Social Security Admin. Administrator and Mental Hygie is marked other traumatic event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Timmons ည Catherine Cookus Harry J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important; If item 27 is any injury or other traconce. Moonshell Drive Ocean Pines, Maryland 21811 Patricia A. Gulyas/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park 10/15/2011 Elkridge, Maryland 20c. Location - City or Town, State 20a. Method of Disposition Fix Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signatur of Funeral Service Licer MD 21043 4112 Old Columbia Pike Ellicott City, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMENT Ph_sician/ HEIM disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Exam Due to (or as a consequence of): resulting in death) Last physician Physician/Medical The law requires that the death certificate be Box 68760 the use as attending IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Day Pregnant at time of death 5 Other (specify) n signed by the at ald be detached for 1 ☐ res ∠ ☐ g ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deaths. þ 4 Unknow 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 perform death? 1 Yes 2 No this certificate I or Attending Physician: after death. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Director; After iniury 1 Natural 5 Pending Accident Investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check

State Registrar

within 2

address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 10, 201 J Roger Milio 10:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Gilchrist Hospice Care If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) **Funeral** 8. Date of Birth g. Birthplace (State or Foreign Birthpiac Country) I<u>taly</u> 1 M 2 □ F Dec 15, 1919 123-07-1519 91 Director Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho **Funeral Director** 10a. State 10h County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 1 Tyes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6440 Lochridge Road 21044 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1♣ Yes 2 No If Yes, Give þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify Year or Dates White other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I once. Lawver Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Giuseppe Milio Rosario Barca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Milio Marshall/daughter 6440 Lochridge Road Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/14/2011 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Dopation 5 Other (Specify) Crownsville, MD rownsville Veteran Ceme 22. Name and Address of Facility larry H. Witzke's Family F.H.Inc. e of Funeral Service Licens 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part \Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sici_n COMPLICATIONS OF HEARS Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to lor as a consequence of law requires that the death certificate be executed signed by the attending physician and defacthed for use as the burial-transit Cause (Disease or liniur) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, EMPHYSEMA 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown peen 24b. Were autopsy findings available 24a. Was an page 2 s has autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 24 hours after death. Funeral Director: After 28d. Describe how injury occurred 1 🔊 Natural 5 Pending iniury work?

1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

within 2

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN

6336

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

064395

CEDAR LANE

29d. Date signed (Month. Day, Year)

COLUMBIA. MB 21044

OCTOBER 10,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011 34023

		1- For State Certification Cer	icate of Death	Reg. No.						
Physic Medical Exam		Decedent's Name (First, Middle, Last)		Date of Death Month Day	3. Time of Death					
viedicai Exam	iine	Richard Anthony Mundey 4a. Facility Name (if not institution, give street and number)	11 1528 hrs							
		12489 San Jose Lane	4b. City, Town, or Location of Death Lusby	The second secon	Calvert					
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last to								
Director		215-86-0420 1XM 2DF 49	Yrs. Months Days Hours Min	1/9/196	2 Foreign Country) DC					
	Z DC									
v any			wn or Location		10d. Inside City Limits					
Aaryland 28a-f show 1 at once.	5	MD Calvert	Lusby		1 X Yes 2 No					
Mary 28a-	Director	10e. Street and Number	10f. Zip Code	10g. Citi	izen of What Country?					
eath with the Maryland items 23a or 28a-f sho ust be notified at once.			20657		USA					
th will	uneral	11. Marital Status 1 Never Married 2 Married 2 Married Forces?	 Was Decedent of Hispanic Origin? (Spirit Yes, specify Cuban, Mexican, Puerto 	pecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc. 					
er dez	ш	3 Widowed 4 Divorced If Yes Give Year	1 Yes 2 X No specify:		Specify: White					
urs afi tural'	d b	15 Decedent's Education (Specificantly highest and completed)	a. Decedent's Usual Occupation (Give kind of							
72 ho	ete		during most of working life. DO NOT use reti	red)	,					
15-0036 The within 72 Hygiene. d other than "	Complete	9	Mailroom Helper	N	ewspaper					
15-0 iled y Hygi d othe			18.Mother's Name	(First, Middle, Maiden	Surname)					
ID 21215-00; should be filed within and Mental Hygiene. 7 is marked other titnatic event, the Med	Be C									
and 2 shou fealth and N tem 27 is n traumatie	ဥ		19b. Mailing Address (Street and Number or F 12489 San Jose Ln.							
e, MC 1 and 2 sl Health ar item 27		20a. Method of Disposition 20b. Place	e of Disposition (Name of cemetery,	·	Location - City or Town, State					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers III and Tall and Mental Hygier III mportant If time 71 is marked other than "natural", or items 23a or 23a-f she injury or other traumatie event, the Medical Examiner must be notified at once		Ch -	atory or other place)	10/11	eltsville, MD					
litin nit. Pa artmen ortan		4 Donation 5 Other Specify: CITES 21. Signature of Funeral Service Licensee								
Dem Dem Dep		(Word	PO Box 430, Dun		ood F.H., P.A. 20754					
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line Citalopram To		,	ock, or heart Approximate Interval					
/Medical Examiner			Cardiovascular Diseas		Between Onset and Death					
		or condition resulting in death) Due to (or as a consequence of):								
	er	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):								
	min	cause. Enter Underlying Cause (Disease or injury that initiated								
cuted and transit	Examiner									
	Medical		me,g921,11-16-11 sm							
760, icate be ex physician the burial	Wed	IF FEMALE: 23c. If yes, outcome of pregnance	_	230	d. Date of delivery					
Box 687; death certificate at the attending and for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)							
e ± e	Ph	Part II. Other significant conditions contributing to death but not resulting	ing in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?					
P.O es that ti igned by be detacl	d by	25		1 Yes 2	No 3 Probably 4 V Unknown					
rds, requir been s	Completed			24a. Was an	24b. Were autopsy findings available					
e law e has ge 2 sh	mpl			autopsy performed?	prior to completion of cause of death?					
Division of Vital Records, ral or Attending Physician: The law requires after death al Director: After this certificate has been side in by the funeral director, page 2 should be		25 Was case referred to medical	26.Place of Death (Check	1 Yes 2 N	o 1 Yes 2 No					
Vita ysicia his cer	o Be	examiner?			nce 6 🗹 Other: Scene					
ing Phys After this funeral di	7: To	27. Manner of Death 28a Date of Injury 28b	. Time of Injury 28c. Injury at Work?	28d. Describe how inju						
	iğ.	1 K Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No							
Division ours after death cours after death cours after death filled in by the	tific		farm, street, factory, office building, etc.	28f. Location (Street a	nd Number or Rural Route Number, City					
10. 13 to 10.	Certification:	4 Homicide determined (Specify)		or rown, state)						
To the Hos within 24 h To the Fun		29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, done) Medical Examiner: On the basis of examination and/or								
To the within comp	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)					
		1	O.C.M.E.		ober 14, 2011					
		30. Name and address of person who completed cause of death (Item 23a)	6	000						
ŀ		Zabiullah Ali, M.D. Assistant Medical Examiner 9		MD 21223						
St	ate	31 Date filed (Month, Day, Year) 32. Registrar's Signature								
Regist		OCT 17 2011 Beneva B.	parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 0 George Frank Miller Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4559 Sixes Road Prince Frederick Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 ₩ M 2 🗆 F 11 1 29 P 1 9 29 **Director** 81 128-22-0666 Usual Residence of Decedent or 28a-f show 10a, State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 11672 Big Bear Lane 20657 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Scheduling Manager Airlines filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) þe Frank Miller Josephine Frances Geld t. Page 1 and 2 should be rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Jacqueline R. Bradley / Wife 11672 Big Bear Lane, Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖼 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/12/2011 Alexandria, Virginia Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 22. Name and Address of Facility P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ Onset and Death Lung cancer disease or condition resulting in death) Medical Due to (or as onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed rain that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown in 24 hours after death.

he Funeral Director: After this certificate has been upleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 **N**O 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the d within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct 10. Physician/ Emily E. McKenzie 19:07 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XX Days Min. Months Hours Country)
Maryland 220 16 8173 87 Director Oct 9. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "nature!" any injury or other traumatic events once. 10a. State 10h County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Prince George's Upper Marlboro 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12100 Fenno Road 20772 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give 1 ☐ Yes 2 XXNo Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Farming 10 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Edward Coombs Marion Elizabeth Winkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill M. Primrose (Daughter) 9607 Croom Road, Upper Marlboro, MD 20772 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 10/15/2011 Carmel Cemetery Upper Marlboro, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Sign ture of Funeral Service Licenmo1553 Ferry Road Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) there-level. Medical o (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknow Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Watural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34026 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:20 A Physician/ James J. Manion, Jr. Oct. 10 Pay2011 Year Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 12817 Asbury Drive Fort Washington Social Security Number f Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 8. Date of Birth Hours (Month, Day, Year March 7, 1 Director 579 48 8660 77 1934 Usual Residence of Decedent or 28a-f show the notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Fort Washington 1 U Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 12817 Asbury Drive 20744 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1954–1956 1 Yes 2 W No Specify: 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Dept of Commerce Economist of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic events. မ James J. Manion, Sr. Josephine Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adalene E. Manion (Wife) 12817 Asbury Drive, Fort Washington, MD 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/11/2011 Lee Crematory Clinton, MD . Sig 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria a re of Funeral Service Lice MOIS 27 Ferry Road, Clinton, MD 20735 23a. Fat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pancreas Cancer Medical Due to (or as a consequence of) Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as a consequence of) signed by the attending physician and defacthed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2XX No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide City or Town, State 24 hours a Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

complete only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) steller. O the D23743 October 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenway Court, Greenbelt, MD 20770 301 982 9800 Martin Weitz, M.D. Year 3 2011 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) october 4, 2011 Physician/ 11:07 a M Thomas Patrick McCaffrey Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Bryans Road 6794 Amherst Road g. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Dec. 3, 1929 . Social Security Numbe Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours 1 **X** M 2 □ F Pennsylvania 189-22-3312 Director Usual Residence of Decedent shov 10d. Inside City Limits 10c. City, Town or Location at Director notified 1 🗌 Yes 2 🛛 No 28a-f Maryland Charles Bryans Road 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö be U.S.A. 20616 23a 6794 Amherst Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 17 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 □ Divorced "natural", Completed W11 White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government Intelligence 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanfield Thomas J. McCaffrey Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Poplar School Rd., Centreville, Md. 21617 Sheila L. Cross Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)Oct. 6, 20c. Location - City or Town, State 20a. Method of Disposition i = 10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Funeral Service 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter the lie ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MYOCARDIAL IN FARCTION Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MELLITUS DIABETES Sequentially list conditions, Examine Due to for as a sone-quence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day ed by the a detached t 1 L Yes 2 L Hospital or Attending Physician: The law requires that the C24 hours after death.
Funeral Director: After this certificate has been signed by th signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHROM ! C OBSTRUCT VE PULMONTY 23e. Did tobacco use contribute to the cause of death? DISTASE Yes Be Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, been si MEZLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the autopsy performed 1 🗌 Yes 2 🗌 No Yes Z 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, examiner? Other: 4 \(\text{Nursing Home} \) \(\text{X} \end{array} \) Residence 6 \(\text{D} \) Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifie 29c. License number 028281

State Registrar

3B1041

SI. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENJERS

, 9131 PISCATAWAY RD, CLINTON, MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34028 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cleyta Physician/ Belle Month O 3:00 а м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Cambridge Dorchester Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 1 M 2 F Months Days Year) 1931 Min. Hours Sept. 21. Director 214-28-7838 Vrs Maryland 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 28a-f Dorchester Cambridge and 2 should be filed within 72 hours after death with the Man 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 740 Foxtail Drive Apt. 209 21613 USA items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 X Yes 2 No
If Yes, Give 1949-52
Year or Dates 1949-52 Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify. "natural", 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) d Mental Hygiene. marked other tha College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Hammond Windsor Hilda Mills and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health sitem 27 i Lynn F. Morris daughter 4831 Bucktown Road, Cambridge, MD 21613 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 Department of I Important: If ite any injury or ot once. 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State Crematory of Delmarva 10/8/11 Delmar. DE 4 ☐ Donation 5 ☐ Other (Specify) tore of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dneumonia disease or condition **Medical** resulting in death) Due to (or as a consequence of): Examiner Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed obstructive lung disease Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Day Month Pregnant at time of death Year signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by rheumotoid arthritis, Completed 1 Xyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s certificate performe Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes မ 2 No Other: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural N injury 5 Pending 1 ☐ Yes 2 ☐ No the 1 Accident Suicide Investigation 6 Could not be completed filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier y_{λ} and address of person who completed cause of death (Item 23a) (Type, Print) 100

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item of Maryland Poepartment of Health and Mental Hygiene 34029 Certificate of Death Decedent's Name (First, Middle, Last) James Ronald Martin 2. Date of Death 3. Time of Death Physician/ Year Medical **Examiner** give street and number. 4b. City, Town, or Location of Death 4c. County of Death Jast birthday) Yrs. If Under Year If Under 24 Hrs. Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ■ M 2 □ F Days Months for Lyence Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be m 10e Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Porces?

1 Yes 2 No
If Yes, Give
Year or Dates. 11. Marital Status 12. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Baltimore, Maryland 21215-0036 þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Rusiness Industry (Specify only highest grade completed) Elementary/Şeconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-11-2011 21. Signature di uneral Service Licensee 22. Name and Address of Facility urran-Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ INTRACRANIAL HEMORRHAGE disease or condition) Medical resulting in death) Examiner CEREBROVASCYLAR INFARCTION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or linjury that initiated events ATHERO SCLEROTIC CARDIOVASCULAR DISEAS and resulting in death) Last nding physician ase as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant atten for us 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Year Day Yes 2 No ed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, IT TPERTENSION, ATRIAL FIBRILLATION Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending s after death. the Investigation 1 🗌 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier 1 📉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

cause of death (Item 23a) (Type, Print)

MD 321 Brown INC DIK AVE (

nax ATTENDING MD

0053

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State	State of Maryland / [Department of Health	and Mental Hygi	001	0100
			Registrar		Certificate of Death		g. No. 201	3403
	Physici Med		1. Decedent's Name (First, Middle, Last) Hazel Ma	ry Moloc	K	2. Date of Death	Day Year	3. Time of Death
	Exami		4a. Facility Name (if not institution, give street		4b. City, Town, or Location		4c. County of Death	
				-sing Center		dge	Dorche	
	Funeral Director			2 MF 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 1 Year Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day,)	(ear) 9. Birthp Count 1918 Mar	lace (State or Foreign ry) 4 / a nd
7111	land show dat	٦	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town	or Location			
1	Maryland 28a-f sho otified at	ecto	MD Dorches				"	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
1	Se not	늘	10e. Street and Number	TET Ca.	Mbridge 10f. Zip Code	10	ng. Citizen of What Coun	
1	death with	Funeral Director	809 Radiance	Drive	2/6/3		USA	
1	r death		11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - America Black, White, e	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at	od by	2 Widowad 4 Diversal	1 ☐ Yes 2 ☑ No f Yes, Give Year or Dates.	1 ☐ Yes 2 ☑ No Specify.		Specify: Bla	
5-0	s filed within 72 hour tal Hygiene. ed other than "natul event, the Medical	Completed	15. Decedent's Educa (Specify only highest grade c	ion 16a	Decedent's Usual Occupation	t of worlden	6b. Kind of Business Ind	
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9	led within I Hygiene. other th a ent, the l	Be	17. Father's Name (First, Middle, Last)		HOUSEWIFE	er's Name (First, Middle, Ma		16.
/lan	should be filed within 7 and Mental Hygiene. is marked other than aumatic event, the Me	٩	Stephen B.	Wilson			un9	
Aan	shoul and I		19a. Informant's Name/Relationship (Type, F		Mailing Address (Street and Number	er or - ural Route Number, C	City or own, State, Zip C	· .
e,	1 and 2 should be frealth and Men the and Men item 27 is marked other traumatic		Rulene Mi) 20a. Method of Disposition	LOCK 8	09 Radiance D	rive Campr	idge, Maryla	and 21613
nor			1 1 Burial 2 ☐ Cremation 3 ☐ Rem		Disposition (Name of y, crematory or other place) CK Cemetery		Oc. Location - City or Tov	
Baltimore,	permit. Page Department i Important: It any injury or		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Melo	22. Name and Address of Facilit	N 1 1 1 1 1 1 1 1	lienna, M	aryland
B	Depar Impo any ir		21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee C. J. 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one ca	enry	Henry Funera	agton Stical	ubridge Mi	0.21613
Н			,	ons that caused the death. Do no use on each line.	ot enter the mode of dying, such as	cardiac or respiratory arrest	,	interval between
	Ph_sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Congi	estive Henry T	Fallure		Onset and Death
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68760	tificate ng phy as the		IF FEMALE:					
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Box	es that the dea signed by the a I be detached f	Physician/M	1 Yes 2 No	☐ Pregnant at time of death ☐ Unknown	5 Other (specify)		Month I	Day Year
P.O.	that t gned b		Part II. Other significant conditions contributions	iting to death but not resulting in	the underlying cause given in Part I	I. 23e. Did toba	cco use contribute to the	cause of death?
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Records,	law re has be ie 2 sh	Completed by	Chrinic Inema	(Ingussi	ciency	24a. Was an autopsy	prior to com	sy findings available inpletion of cause of
E R	ician; The la certificate ha rector, page		25. Was case referred to medical				ed? death? No 1 \(\sum \) Yes 2	2 2 740
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Division	al or Attences after death	Cer	4 Homicide determined	le. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural F State)	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: C	To the best of my knowledge, do	eath occured at the time, date and p	place, and due to the cause	(s) and manner as stated	
	thin 24	Me	only one) 3 L Certifying Nurse Pra	the basis of examination and/or tioner: To the best of my knowle	investigation, in my opinion, death oc dge, death occurred at the time, date	and place, and due to the ca	place, and due to the caus nuse(s) and manner as stat	se(s) and manner stated.
	\U_\ E≥E8		29b. Signature and title of Artifier		29c. License number	290	d. Date signed (Month, Di	ay, Year)
	Vo	-	30. Name and address of person who comple	ted cause of death (Item 23a) (Ty	/pe, Print)) [10	
	- 01-0		2 yant Newmie	D.O. 331	Morchester 1	tre, Svite 1	Gentridgel	4/ 21613
	Stat Registra	9	OCT 12 2011	A Service S.	park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 201T Physician/ October 7:52 Joseph Murphy Michael Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign Country) D . C . 8. Date of Birth (Month, Day, Nov. 30, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 1 🖾 M 2 🗆 F Months Hours 57 T953 212-52-0506 Nov. **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location at 10a. State 10b. County Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 🗌 Yes 2 🔀 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20906 14508 Kelmscot Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Specify:White Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Plumber permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Mary Eva Cawthon Peter J. Murphy, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9913 Ferndale Avenue, Columbia, MD 21046 Kathy Corsillo/Sister Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Oct. 10, 1 Burial 2 2 Cremation 3 Removal from State Alexandria, VA Metropolitan Crematory 2011 4 Donation 5 Other (Specify) of Funeral Service Licensee Francing Address & Faritins Funeral Home Inc. le Cellis 500 University Blvd. W., Silver Spring,MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 3 Onset and Death Immediate Cause (Final Acute Respirtory Distress Syndrome Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Multi-System Organ Dysfunction Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury End-Stage Renal Disease and that initiated events Due to (or as a consequence of) resulting in death) Last physician sthe burial Physician/Medical of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ☐ Live Birth 2 ☐ Fetal deat☐ Pregnant at time of death☐ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Pulmonary Artery Hypertension Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate has Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certifical mpleted filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 H No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA ည 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: To the Hospital or Attending 1 Natural 5 Pending Division 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 L. Certifying Nurse Practician: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practioner: To the Set of my Woulledge, death admin 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Keith Horvath, MD
31. Date filed (Month, Day, Year)
OCT 11 2011

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30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D62283

8600 Old Georgetown Road, Bethesda, MD 20814

October 4, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34032 State of Maryland / Department of Health and Mental Hygiene 🤈 **1 –** For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 2011 1220 PM M Sanford Arthur Miller 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 5450 Whitley Park Terrace #704 Montgomery Bethesda 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 053-24-0731 05/12/1931 1**X**□ M 2 □ F 80 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No MD Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20814 United States 5450 Whitley Park Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. rmed Forces? Black, White, etc. 1 Never Married 2 X Married White If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Education 5+ <u>Dean Emeritus</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Kenter Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 901 Cramer Avenue Lexington KY 40502 Wallis Miller – daughter 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Sharon Memorial Park 10/5/2011 Sharon, MA Donation 5 Other (Specify) 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
II/O Rockville Pike Rockville MD 20852 M01163 21. Signature of Funeral Service Licensee. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pneumonia resulting in death) Due to (or as a consequence of): Parkinsons Disease Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of)

Ph_sician/ Medical **Examiner**

Physician/

Medical

Director

þ

Completed

Be

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

and Mental Hygiene.
is marked other than

Department of Health and Mental h Important: If item 27 is marked oth any injury or other transconce

death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

dical	d d		
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date of delivery Month Day Year	
ompleted by Pr	Part II. Other significant conditions confidence Congestive Hea	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? • 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? performed? 1 Yes 2 No 1 Yes 2 No
S	25. Was case referred to medical	26. Place of Death (Chec)	21
o Re	avaminar?	Lou	ome 5 Residence 6 Other (Specify)
ertificate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred
erti	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying trurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

October 4, 2011

29c. License number

MD12915

State Registrar

Medical

29a. Certifier (Check

31. Date filed (Month, Day, Year)

3 [

29b. Signature and title of certific

OCT 11 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George Bren MD 2440 M Street NW Washington DC 20037

32. Registrar's Signature barlos

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Decedent's Name (First Middle, Last) October Physician/ McNish 2011 1:30 $a^{\,}$ M Rosalie Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery 11301 Wacomor Drive Germantown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 WV 5. Social Security Number 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday **Funeral** Months Feb. 10, ^{Year} 1926 1 □ M 2 🖾 F 213-22-4590 85 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov aţ 10a. State 10h County 10c City Town or Location filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🛱 No Germantown MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20876 USA 11301 Wacomor Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. the Medical Examiner Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) 0 Specify: White Completed by 1 Never Married 2 Married 🗌 Yes 2 😾 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) National Transportation and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Assistant to Chairman Safety Board traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Olga Smith Edward Minard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trac Roseneath Court, Olney, MD 20832 Kathryn A. Simone/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Oct. 10, Page 1 cemetery, crematory or other place) 1 Burial 2XX Cremation 3 Removal from State Alexandria, VA Metropolitan Crematory 2011 4 ☐ Donation 5 ☐ Other (Specify) rancis J. Collins Funeral Home Inc. O University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licen on the Co MD 20901 23a. Part 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Glioblastoma disease or condition resulting in death) a. Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this cartificate has been considered by the this cartificate has been considered by the property of th 10 that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 2 XNo After this certificate has been signed by the a funeral director, page 2 should be detached it Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 2 N 25. Was case referred to medical **Director**: After this certific I in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 ☐ Yes 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 4 - Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 To the Comple 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

ORIGINAL

MD35067

3800 Reservoir Road, N.W, Washington, DC 20007

October 6, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar 2. Date of Death Decedent's Name (First, Middle, Last) 920 AM M Physician/ October 0 4 Mark Ellis Mausner Medical . County of Death Montgomery 4b. City, Town, or Location of Death
Potomac 4a. Facility Name (if not institution, give street and number) **Examiner** 29 Piney Meetinghouse Court 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Social Security Number Days Hours Min. **Funeral** Brooklyn, NY 083-40-9908 1 🖾 M 2 🗆 F 10/29/1951 Director 59 Yrs Usual Residence of Deced 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehrming or other traumatic event; the Medical Experience. 10c. City, Town or Location 10b. County 10a. State Director 1 X Yes 2 No Potomac Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20854 29 Piney Meetinghouse Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2X No ð White Specify: 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Medical College (1-4 or 5+ Physician 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Bernice Koonin Eugene Mausner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen Lee Sprintzin Mausner wife 29 Piney Meetinghouse Court Potomac MD 20854 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition

1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Date Falls Church, VA King David Mem Gardns 10/6/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville 21. Signature of Funeral Service Li M01163 23a. Part 1. Enter the disease, or an plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur 3. He only one cause on each line. Approximate Interval Between 14 Months Immediate Cause (Final Glioblastoma Multiforme Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine by the attending physician and The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy Day Month in the past 12 months? Pregnant at time of death Unknown page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by þ 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? peen 24a. Was an autopsy performe this certificate has 2 🗌 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: the funeral director, Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🗓 No မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: injury 1 Natural 5 Pending after death. Investigation Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours after de the Funeral Directo toletely filled in by the 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year)

Registrar

State

29b. Signature and to

Ralph V.

31. Date filed (Month, Day, Year

OCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sig

Boccia MD 6420 Rockledge Drive #4100 Bethesda MD 20817

29c. License number

D29675

10/4/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Eve Nadas		St - For State Registrar	ate of Maryla		artment of rtificate of		Mental H		eg. No. 20	111 3403
Physician Medical Examine	1/	 Decedent's Name (First, Midd 	le,Last) Eve Marie	Nadas				Date of Dea Month October 1	Day Year	3. Time of Death 1640 hrs
		4a. Facility Name (if not institution 8601 Manchester Roa		mber)	4	b. City, Town, or Lo Silver Spring	ocation of Death		4c. County of Montgom	
Funeral Director		5. Social Security Number 119-38-5221		7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24Hrs Hours Min.	7	08,1958	9. Birthplace (State or Foreign Country) New York
от апу	r	Usual Residence of Decedent 10a. State 10b. County			, Town or Locati		Research Contr			10d. Inside City Limits 1 Yes 2 X No
aryland Sa-f she		Maryland Mona	tgomery			10f. Zip Code	lver Spr	LNG 1	0g. Citizen of Wha	at Country?
r death with the Maryland or items 23s or 28s-f show must be notified at once.		8601 Manches 11. Marital Status	12. Was Dece	edent Ever in U	.S. 13. Wa	2 s Decedent of Hispans, I	0901 anic Origin? (Sp Mexican, Puerto	ecify Yes or No	o- 14. Race - White,	U.S.A. American Indian, Black, etc.
rs after deatl	2	1 Never Married 2 M 3 Widowed 4 X Div 15. Decedent's Education (Spe	1 Yes	2 X No	1	Yes 2 X No	specify:		Specify:	White iness/Industry
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. The filem 77 is marked other than "natural", or items 23a or 28a-fahe other traumatie event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)				ost of working life. E Registe	no NOT use reti	sed)	Hed	alth Care
Baltimore, MD 21215-005, permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene Important: If item 27 is marked other injury or other traumatic event, the Med	e n	17. Father's Name (First, Middle		n Surname) Let Gruner City or Town, State, Zip Code)						
and 2 should I stealth and Mer item 27 is man traumatic ev	-1	19a. Informant's Name/Relations Joseph S. K 20a. Method of Disposition		n	8601 N	Mancheste	r Rd#			ng, MD 20901 City or Town, State
Baltimore, Poemit. Pages I and Department of Healt Important: If item ajury or other tra		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other S	n 3 Removal fro		crematory or oth	er place)				
Baltir permit. P. Departme Importan injury or		21. Signature of Funeral Service	Licensee MO152	24	118	00 New Ho	ampshire	ave.,	Silver S	od, Maryland ral Home, Inc. Spring, MD20904
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	on,Cita	lopram					Approximate Interval Between Onset and Death
	Jeu	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a							
uted ansi		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a							
be executed sician and turial - transi	- dica	X UNPENDED	AMENDED 2	23a,27,2	28a-f,pe	er me,g92	0 10–26-	-11 sm		
Box 68760, e death certificate buthe attending physiced for use as the but	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1								delivery Day Year	
F, P.O. Boires that the designed by the	<u> </u>	Part II. Other significant condi			esulting in the u	nderlying cause giv	ven in Part I.			oute to the cause of death? Probably 4 Unknown
ords aw requ as been 2 shoult	- completed							1 Yes	psy pr prmed? de	Vere autopsy findings available fior to completion of cause of eath? Yes 2 No
Vital Recysician: The Bhis certificate Bhis certificate Bhis certificate Bhis certificate Bhis Communication	e e	25. Was case referred to medica examiner?	Hospital: (npatient 2	ER/Outpatient		of Death (Check Other Nursin		Residence 6	Other: Scene
on of View or and of View of the control of View of Vi		1 V Yes 2 No 27. Manner of Death 1 Natural 5 Pen	ding fd 10	of Injury Day,Year)	28b. Time of In		at Work?		how injury occurre	ed tablets
Division of Varieties to the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director. completely filled in by the funeral	Certification	3 X Suicide 6 Cou	istidation I	of Injury - At h	ome, farm, stree	et, factory, office bu		28f. Location (or Town, 5	Street and Number State) 8601 M ilver Spr	r or Rural Route Number, City Manchester Rd. ing, Md.
o the Hosp aithin 24 ho o the Func ompletely f	ਰ '	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes miner:On the basis of and manner st	of examination a	lge, death occur and/or investigat	red at the time, date ion, in my opinion,	e and place, and death occurred a	due to the cause at the time, date	and place, and du	ue to the cause(s)
3-PEND	Š	29b Signature and title of certific	•			29c License O.C.N			29d. Date signer October 14,	d (Month, Day, Year)
	-	30. Name and address of persor	n who completed caus sistant Medical E			more Street, E	Baltimore, MI	D 21223		
Stat Registra	te ar			gistrar's Signat						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:20 9 October 0 Physician/ Nutwell-Simpson Ray Lisa Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner Anne Arundel Annapolis Anne Arundel Medical Center 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 5. Social Security Number 1 🗆 M 2 🗶 F 01-16-1967 **Funeral** Hours Maryland 44 Director 215-96-2461 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f show 10b. County 10a. State with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Deale Anne Arundel MD 10a. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20751 5700 Nutwell Sudley Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. the Medical Excession. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 ☐ Yes 2 🗓 No þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. Specify: Baltimore, Maryland 21215-0036 If Yes Give White 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) healthcare health caregiver 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ၉ Leighann Lillian Conrad Nutwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5700 Nutwell Sudley Road, Deale, MD Michael L. Simpson, spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Alexandria, VA Metropolitan Crematory 10/13/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signatur of Funeral Service Licenses 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any along to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence of the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day Month in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 4 ☐ Pregnant g ☐ Unknown ed by the a detached f signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 2000 page 1 Yes ours after death.

eral Director: After this certificate I filled in by the funeral director, page 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No □ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined within 24 hours a

To the Funeral C

completed filled Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day 32. Registra s Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Bernard NEWMAN 2011 11:00 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital 01ney Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min. 129-12-0192 Director 1 X M 2 □ F 91 192þ New York March 18, shov 10a. State 10b. County 10c. City, Town or Location Director r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 🗆 Yes 2 🛣 No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20906 14809 Pennfield Circle #203 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent Ltd.
Armed Forces?

1 Ves 2 No Navy
If Yes, Give
Year or Dates. WW II 1 Never Married 2 Married þ Maryland 21215-0036 Specify: white 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed 16b Kind of Business/Industry Pension Benefit Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Guarantee Corp. Chief Accountant Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, should be file and Mental I is marked o မှ other traumatic Albert Newman Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar. Important: If item 27 is any injury or any 14809 Pennfield Circle #203, Silver Spring, MD 20906 Rae Newman, Wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Judean Memorial Gardens 10/10/11 Olney, MD Donation 5 Other (Specify) 21. Signature of Fune Torchinsky Hebrew Funeral Home NW, Washington, DC 20012 23a. Part Lever the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** eaquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a Exami The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physiciar Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ ☐ Live Birth 2 ☐ Fetal ass.☐ Pregnant at time of death☐ Unknown in the past 12 months? Day ed by the a detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed be should be deta à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate To the Hospital or Attending Physician: 25. Was case referred to redical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မူ 1 Inpatient 2 -ER/Outpatient 3 DOA funeral 27. Mann T Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 2011 20+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

18/01

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Norma Lee O'Neal 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rehab omico 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🗆 M 2 🗓 F July 14, 1923 Min. Days Hours Mary Tand 88 218-12-1985 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examirer must be notifie at 10b. County 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Parsonsburg Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21849 7474 Rachel Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural", 3 Widowed 4 X Divorced Completed permit. Page 1 and 2 should be fled within 72 houn Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly injury or other traumatic event, the Medical any injury or other traumatic 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Clothing Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Manufacturing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Maude Elliott John Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28285 Riverside Drive, Salisbury, MD 21801 Virginia L. Marvel/Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Crematory Of Delmarva 10/9/2011 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 3171
IZIZ Old Ocean City Road, Salisbury, 21. Sign thre of Funeral Service Licenses MD 21802 Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sach line. a. Part 1. Enter the disease, or con shock, or heart failure. List only , or complications the st only one cause of haimer Immediate Cause (Final Physician/ reers disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death
Unknown 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day 1 Yes 2 No signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 4 Donknown Records, 2 🗌 No 3 Probably umould Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 1 has 1 Yes 2 No certificate Hospital or Attending Physician: Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 1 Yes 2 ZINO ည 1 Inpatient 2 ER/Outpatient 3 DOA ANursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 🕻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year, 10 10 and address of person who completed cause of death (Item 23a) (Type, Print) ame Mo 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

1-07468 Connie Lynn Rizz		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State										
Physicia		1- For State Registrar 1. Decedent's Name (First, M	iddle,Last)		Certifica	ate of	Death		2. Date of D		Year	3. Time of Death
Medical Examir	ıer		LYNN RIZZO			14	b. City, Town, or L	agation of Dogth	Month October		1 c. County of D	1403 hrs
		4a. Facility Name (if not instit Chester River Hosp		iumber)		1	Chestertown				Caroline	Gau
Funeral		5. Social Security Number	6. Sex	7. Age	e (In yrs. last birth	nday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	-		/DD/YYYY) 9	. Birthplace (State or oreign SALEM CounMyEW JERSEY
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Baltimore permit. Pages 1 Department of H Important: If i injury or other		21. Signature of Fureral Service Licensee 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901										
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	je.	if any, leading to immediate cause. Enter Underlying Cat	Due to (or as	a conse	equence of):							
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and and	Physician/Medical	UNPENDED	d AMENDED)								
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be except. After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial.	Š	IF FEMALE: 23b. Was decedent pregnant	in the	, outcon	ne of pregnancy	□ Fot	al death 3	Ectopic pregna	ancy	23	d. Date of del	livery Day Year
ox 68 th certi	ig	past 12 months? 1 Yes 2 ✓ No 9	4 Pres	gnant at	time of death 5	\vdash	ner (Specify)				morni,	24,
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. Ther this certificate has been so birector: After this certificate has been so led in by the funeral director, page 2 should.	Completed by									topsy	prio	e autopsy findings available r to completion of cause of
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Vital Rec hysician: The I this certificate I	Be	25. Was case referred to med examiner? 1 ✓ Yes 2 No	Hospital:	Inpatie	nt 2 ✓ ER/Ou	utpatient		of Death (Check Other Nursir		Resid	ence 6 (Other:
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Division of Nother Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral		29a. Certifier 1 CertifyIn	g Physician: To the b Examiner: On the basi	est of my	y knowledge, dea	th occurr	red at the time, da	te and place, and death occurred a	I due to the cat the time, da	ause(s) a ate and pl	nd manner as lace, and due	stated. to the cause(s)
To To Com	Medical	29b. Signature and title of ce	and manner				29c, License					(Month, Day, Year)
		ma		1	D		O.C.N	И.E.		Oc	tober 7, 20)11
12	Ī	30. Name and address of per Russell Alexander			eath (Item 23a) al Examiner	900 \	W. Baltimore	Street, Baltin	nore, MD	21223		
Sta		31. Date filed (Honth, Day)			's Signature							
Regist	rar	001 11 7	Leve	~	19. 14 W	N.			C	CME		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#19aperFH, 10/11/11; BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct. Day 2011 Year Physician/ 7, 10:25 A M Romandetto Robert Anthony Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Potomac Montgomery 12910 Travilah Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 Å M 2 □ F Nov. 17, Months Days Hours Min New York 109-24-5285 78 T932 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, t<u>he Medical Examiner must be notified</u> at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Potomac 1 X Yes 2 ☐ No MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20854 12910 Travilah Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ò 72 hours after 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: r Yes, Give Year or Dates 1954 – 56 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Logistics Company President Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental For them 27 is marked of Item 27 is marked or other traumatic eve ည Angelina Ruggiero Domenic Romandetto 19a. Informant's Name/Relationship (Type, Print)
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Romandetto/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20854 12910 Travilah Road Potomac, Maryland 20b. Place of Disposition (Name of Me tropo III an 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1

Burial 2

Cremation 3

Removal from State Oct 2011 Alexandria, Virginia 5 Other (Specify) 4 Donation Crematory DeVol Funeral Home 21. Signature of M01315 22. Name and Address of Facility 2222 Wisconsin Ave., N.W. Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Physician/ anci disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physiciar for use as the buri Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown cate has been si, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this
completed filled in by the funeral of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 2 🗌 No Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29c. License number M 0 035033 - 0.C. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Pishvaian, MD 3800 Reservior Rd., NW Washington, D.C. 20007 31. Date filed (Month, Day, Year) State 11 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 5:24am Malcolm David Rivkin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Country) New York . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth Hours (Month, Day, Year) 12/08/1932 022-28-3272 78 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Tyes 2 X No Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 20814 7801 Fairfax Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 🗓 Yes 2 🗌 No 1956-Black White etc. 1 Never Married 2 X Married 1 Yes 2 No Specify ^{Specify:} Caucasian 3 Divorced 4 Divorced 1962 Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Consulting Urban Planner & Economist 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Ruth Lasker Bernard Rivkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7801 Fairfax Road, Bethesda, Maryland 20814 Goldie Rivkin - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grdns: 10/09/2011 Olney. Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Signature of Funeral Service Licensee MUISGY 20904 ain 11800 New Hampshire Ave., Silver Spring, Mon 23a. Part 1. Enter the disease, or amplic wo's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sake on each line. Approximate Interval Between Onset and Death 26 Days Immediate Cause (Final <u>Subarachnoid Hemorrhage status Post Fall</u> disease or condition resulting in death) 26 Days Post Fall Calvarial, Frontal Contusion Status Left Occipital. Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Status Epilépticus 26 Days Cause (Disease or iinjury that initiated events Due to (or as a consequence resulting in death) Last Dementia 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery ent pregnant 12 months? 2 \(\sime\) No 4 Pregnant at time of death Month Day Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Pick's Disease 24b. Were autopsy findings available 24a. Was an Chronic Kidney Disease autopsy performed' Atrial Fibrillation 1 Yes 2 No 26. Place of Death (Check only one)

Physician/ * Medical Examiner Examine Completed by Physician/Medical

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

signed by the attending physician and do be detached for use as the burial-transit peen To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:

Be

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Certificate:

Medical

Box 68760

IF FEMALE: 23b. Was deceding the past 1 Yes	
23b. Was deced	Ę
in the past	1
1 Yes	

27. Manner of Death

1 Natural 2 X Accident

3 Suicide 4 Homicide

28a. Date of injury (Month, Day, Year) 09/11/2011

25. Was case referred to medical examiner?

1 🔏 Yes 2 🗌 No

5 Pending

Investigation 6 Could not be

determined

1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Noon

At Home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Unwitnessed Fall 1 Yes

28f. Location (Street and Number or Bural Route Number, City or Town, State) 7801 Fairfax Road Bethesda, Maryland 20814 Bethesda, Maryland

ı	29a. Certifier	1 X Certifying Physicia	an: To the best of my knowledge, death occur	ed at the time, date and place, and due to the o	cause(s) and manner as stated.
ı	(Check	2 Medical Examiner	r. On the basis of examination and/or investigation	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s)
ı	only one)	3 ☐ Certifying Nurse F	Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
ı	29b. Signature a	nd title of certifier		29c. License number	29d. Date signed (Month, Day, Y

g Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. Li	cense	nu	mbe	r	
D	7	1	5	ĺ	7

29d. Date signed (Month, Day, Year) October 06, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 8600 Old Georgetown Rd., Bethesda, MD 20886 Natalia Maria Vasquez Martinez,

State Registrar

31. Date filed (Month, Day, Year) 11 2011 OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Manth Physician/ 7:45 A M Lillian Robinson Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth Month Day, June 18, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** Year) 929 1 □ M 2 🏲 F Months Hours North Carolina Director June 37-46-1325 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director Washington 1 X Yes 2 No DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral items 23a 20019 United States 4215 Meade Street NE death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. "natural", or iten edical Examiner r Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: **Black** 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Housekeeping 9th should be filed with and Mental Hygien is marked other th other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First. Middle, Last) ည Joe Plum Lucy Garry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or when 13001 Keverton Drive Upper Marlboro, Maryland Carrie Funches - Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State October 1, Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 21. Signa pre Li Fu e al Service Licer 22. Name and Address of Facility Stewart Funeral Home, Inc. Thu towar Washington, DC 4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ rena1 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami como Cause (Disease or linjury that initiated events resulting in death) Last myxe physician and s the burial-trans Due to or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death ed by the a Division of Vital Records, P.O. signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has certificate Yes or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \square Yes 27. Manner of Death 28b. Time of 28d Describe how injury occurred Certificate: within 24 hours after acc... To the Funeral Director: Aft 1 Natural 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 🗌 Homicide To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 816400G IDR Cheverly mo 20185

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 7 pay 2011 Physician/ 12:15 P M Lillian E. Ross Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (Month, Day, Ye Jan. 13, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 1 ☐ M 2 🛂 F Year) Months Days Hours 90 Yrs. Director 578-22-3663 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location with the Maryland **Funeral Director** be notified 1 🖾 Yes 2 🗌 No Washington DC 10g, Citizen of What Country? 9 10e, Street and Number 10f. Zip Code .s 23a o. r must b United States 20018 2320 Monroe Street NE items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Black, White, etc 0. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural" Completed 3 X Widowed 4 Divorced marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked orther than any injury or other traumatic event, the Nonce. Government Program Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Janie Dixon Jesse Gardner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20018 Charles L. Ross Jr. - Son 2320 Monroe Street NE Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October cemetery, crematory or other place, 1 A Burial 2 Cremation 3 Removal from State Landover, Maryland Harmony 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Furieral Service Licensee 2 Wa 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed after death. physician and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as t attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month ģ Pregnant at time of death Unknown 9 Unknov signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be ESRO, CHF, Diabetes 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of injury
(Month, Day, Year)

28b. Time of injury
injury
28c. injury 2 **X** No မ 1 Yes 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 1017 who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34044 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death October 3 Day 2011 Year Physician/ 10:10 A Rosemary S. Roberson Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Montgomery Silver Spring Manor Care Nursing Home 5. Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Dav. Year) Months Hours Min. 437-32-3015 Director 1 🗆 M 2 🏝 F 1920 Louisiana 91 May 25, Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director must be notified 1 XYes 2 No Silver Spring <u>Maryland</u> Montgomery 10g. Citizen of What Country? 6 10e. Street and Number 10f. Zip Code Funeral 23a United States 20904 2501 Musgrove Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Medical Examiner Black White, etc. or þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Specify:African If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Government Secretary 4 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Llewella Breaux ည Soniat Alphonse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) je 1 and 2 s t of Health a If item 27 i Fort Washington, Md. 931 Amer Drive Theresa Wood- Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition October 11 demeter, cremator or other place Maryland Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 9 Department (
Important: If any injury or once, Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Signature of Funeral Service Licensee Stewart Funeral Home, Inc. 12 1 -20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physicians! Respiratory Failure disease or condition resulting in death) Medical Examiner Atherosclerotic Heart Disease Su summelly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the as 1 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Year ģ Pregnant at time of death Month Day 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed the Hospital or Attending Physician: The 1 Yes 2 No this certificate Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) he Funeral Director; After this appletely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
 injury 5 Pending 1 Yes death. Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 124 hours a Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Jo the only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAITHERS BURG, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N		d / Depa		t of H	leaith a				201		34045
	Physicia		1. Decedent's Name (First, Middle Tatiana	e, Last)	Sch	nidt					2. Date of De Month	ath Da	201	ear	3. Time of Death 9:00 A M
4	Medic Examin		4a. Facility Name (if not institution	, give street and number			4b. City,	Town, or	Location o	of Death	Oct.	T	c. County of [7.00 11
-			Manor Care Pot	omac				Poto	mac			M	ontgon	nery	
	Funeral Director		5. Social Security Number 225–52–9403	6. Sex 1 M 2 F	Age (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir October 2	th Year 19	23	Birthpl Count	ace (State or Foreign Ukraine
	and show	٥	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	d. Inside City Limits
	Maryla 28a-f	Director	Maryland Mon	tgomery		Bethe	sda								1 🕅 Yes 2 □ No
	with the s 23a or 3	Funeral D	10e. Street and Number 5618 Mass. Ave			10f. Zip Code 20816					10g. C	itizen of Wha		ry?	
9036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced		Vas Deced f Yes, spec				cify Yes or No- Rican, etc.)		14. Race - A Black, V Specify:		tc.		
21215-0036	ed within 72 hou Hygiene. other than "nati ent, <u>the Medica</u>	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife									King-of Busin		ustry	
Maryland 2	ould be filed v d Mental Hyg marked othe matic event,	To Be		7. Father's Name (First, Middle, Last) 18. Mother's Nam Ivan Constantinov Alexand										3	
	2 shouth and the and the record traum		19a. Informant's Name/Relationsh Margaret Acker		ce		_				Route Numbe				
Baltimore,	Page 1 and nent of Heal ant: If item 2 iry or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		te C	Place of Dispo emetery, cren k Cree	natory or of	her place	e) O	ct.20	7 1 1		ocation - Cit		
Balt	permit. Page 1 Department of 8 Important: If it any injury or or		21. Signature of Funeral Selvice	MO13	315	22 22	Name and 222 W:	d Addres	s of Facility	y DEV	OL FUNI	ERAL Was	HOME h., D.	С.	20007
~~-	Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each li	ne.	h. Do not ente			g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death
مميد	Medical Examiner		resulting in death)	Due to (or a			rair	110					· <u> </u>		
	d died	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or a	s a consequ	uence of):									
0	te be executed nysician and he burial-transit	ical	resulting in death) Last	Due to (or a	s a consequ	ience of):									
876	rtificat ing ph e as th	Mec	IF FEMALE:	1		-									
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physical phy	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	2 Feta at time of d	Ideath 3	Ectopic p Other (sp		у				23d. Date of Month		ry Day Year
ls, P.O.	uires that the signed by a signed by a ld be deta	d by Pl	Part II. Other significant condition Atrial Fibrill		but not res	ulting in the u	nderlying o	ause giv	en in Part I						e cause of death?
Division of Vital Records,	he law req te has bee age 2 shou	omplet									24a. Was autoperfo	psy	prior	rtocon :h?	sy findings available inpletion of cause of
la	sian: T	Be C	25. Was case referred to medical examiner?					26. Pla	ce of Deat	h (Check		2 L 23 -1\	10	162	2 110
<u>.</u>	Physic this ce al dire	₽	1 🗆 Yes 2 🗓 No			ER/Outpatien		_	4 💹 Nu		me 5 Resid			pecify)	
0 1	ding F th. After funer	cate	27. Manner of Death 1 ☒ Natural 5 ☐ Pendin			28b. Time of injury	м 28	Bc. Injury work?	at Yes 2 🗆	- 1	28d. Describe h	now inju	ry occurred		
Divisio	al or Atten s after dea I Director: d in by the	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determi	not be 28e. Place of Ir	njury - At ho etc. (Specify)					_	28f. Location (\$ City or Tov			Rural i	Route Number,
-	he Hospit in 24 hour he Funera pleted fill∈	Medical	29a. Certifier (Check only one) 1 **Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	of of the second		29b. Signature and title of certifier				7	License					ate signed (M		
				Master				5053	34			0ct	. 5, 2	011	
			30. Name and address of person v Thomas Masterso					#10)4 Mc1	Lean	. Viroi	nia	22101		
	State Registra	_	31. Date filed (Month, Day, Year) OCT 0 7 20								, , 8-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WAN Mont Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10002 Greystone Drive Upper Marlboro Prince George's Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** . Age (In yrs. last birthday, 8. Date of Birth 1 DM 2 Months Min Nov 8, 1955 Director Maryland 577 74 3609 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2XX No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10002 Greystone Drive 20772 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force . or Black, White, etc Completed by 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 2 😿 No If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify. Specify: African American 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Retail marked other : If item 27 is marked other or other traumatic event, Be ift. Page 1 and 2 should be artment of Health and Mental Hy tem 27 is marked ofatic eve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis DeSales Swann Dolores Lee Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonio Glenn (Son) 10002 Greystone Drive, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, Important: It any injury or 4 Donation 5 Other (Specify) 10/14/2011 Lothian, MD Cemetery . Signature of Funeral Sevice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Mar Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Reath Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year 1 Yes 2 J Pregnant at time of death 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🗌 No 1 Tes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 24 hours after death.

e Funeral Director: After this leted filled in by the funeral a 28a. Date of injury (Month, Day, Year) 27. Manner of Beath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date sig 23a) (Type, Print O.)Name and address of person who pleted cause of death (Item ENSE HWY, ANNAPOLIS, M.D. VIEVE 31. Date filed (Month State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Elouise Summers 17:40 P Floy Oct 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. Months Hours Nebraska Director 466 78 6456 86 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at **Funeral Director** 1 🗌 Yes 2 💢 No Temple Hills Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20748 4411 Hargrove Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. , o. þ 1 Never Married 2 Married __ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) ည Myron E. Auble Frances Rebecca Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4411 Hargrove Road, Temple Hills, MD 20748 Marion Mirehouse (Sister) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Oct 12, 2011 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham. MD 21. Signatur of Funeral Ser 22. Name and Address of FacilityLee Funeral Home, Inc 663301d Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital Other: 2 MNo ER/Outpatient 3 DOA ္ဝ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 🗆 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending 1 Yes 2 No Investigation Accident the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check bung Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I Ce 29d. Date signed (Month, Day, Year) 30. Name and addre DC 31. Date filed (Morth Da T 2011 egistrar's Signatur State june

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 4 2011 4:15 a^M Mildred Spedden Seward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cambridge Dorchester Chesapeake Woods Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number **Funeral** Age (In yrs. last birthday) (Month, Day, Year) OV • 4 • 1922 1 🗆 M 2 🕱 Days Min. Maryland Nov. 88 Director 215-12-6406 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matified at 10a, State 10c. City, Town or Location Director MD Dorchester Cambridge 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 1022 Hudson Road 21613 Baltimore, Maryland 21215-0036 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2x No white 1 ☐ Yes 2 ☐ No Specify. 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator dress shop Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Walter Bryan Spedden Bertie Hubbard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1007 Hudson Road, Cambridge, MD Mary Frances Warfield sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Dorchester Mem. Park 10/8/11 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. nature of Funeral Service Licenses 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): the attending physician and thed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Day Month Pregnant at time of death this certificate has been signed by the a director, page 2 should be detached g Unknown Unknown uting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? resignificant conditions conf Completed by 1 Yes 2 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 1 Tes Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other Nursing Home 5 Residence 6 Other (Specify) 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 1 Ratural 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred I Director: After d in by the funer injury work? 5 Pending 2 🗆 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 3 ☐ Suiciae
4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the took of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 3 29b. Signature and title 30 Name and address person who complete ed cause of death (Item 23a) (Type, Print) 3 NARR -Oc 31. Date filed (Month egistrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registrar 3. Time of Death 3:05P. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 9 2011 2011 Physician/ Elizabeth J. Schramm Medical 4b. City, Town, or Location of Death Adelphi 4c. County of Death Prince George's 4a. Facility Name (if not institution, give street and number) **Examiner** Hillhaven Assisted Lvg. Nursing & Rehab Ctr. 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs 6. Sex Feb. 18, 1921 Pennsylvania Days Hours **Funeral** 90 1 □ M 2 🔀 F 186-18-3719 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b. County 10a, State must be notified at 1 🗆 Yes 2 🔀 No Director Beltsville Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 0 20705 23a 12809 Innisbrook Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. White 1 Never Married 2 Married þ Specify: 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) own home College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Sarah M. Diamond Be 17. Father's Name (First, Middle, Last) 2 Joseph L. Simons 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 12809 Innisbrook Drive Beltsville, Maryland 20705 19a. Informant's Name/Relationship (Type, Print) Joan-Marie Stranges /daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Alexandria, Virginia 10/10/2011 Metropolitan Crematory 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Donald V. Borgwardt Funeral Home, 21. Signature of Funeral Service License Maryland 20705 4400 Powder Mill Road Beltsville; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final <u>Parkinson's</u> Disease Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical **Examiner** Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury g properties as the burial-trapes Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day Month in the past 12 months? ō Pregnant at time of death Yes ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. n signed t Alzheimer's Disease; Hypertension; Coronary Artery 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown þ Completed within 24 hours after death.

To the Funeral Director: After this certificate has been since the Funeral director, page 2 should be completed filled in by the funeral director, page 2 should be completed filled in by the funeral director, page 2 should be completed filled in by the funeral director, page 2 should be completed filled in by the funeral director. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Disease autopsy 2 X No ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical 8 B examiner?

1 Yes Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 2 [XNo ၉ 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 5 Pending 1 Yes 2 🗌 No Investigation 2 Accident
3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be City or Town, State) ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature October 10, 2011

Registrar

State

Day, Year)

31. Date filed (Month,

D55559

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas E. Maslen, M.D. 7525 Greenway Center Drive,#312 Greenbelt, Maryland 20770

		•	1 - State Registrar	Cer	tificate of L	Death	Reg	j. No.		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Y	'ear	3. Time of Death
	Medic	al	Cheng Cheng Sun 4a. Facility Name (if not institution, give street and number,		4h City Toyun o	Location of Death	September	29, 20	Dogth	1:00 p ^M
	Examin	ier	404 Viewfield Drive		Salisbu			Wicor		
	Funeral		·	ge (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	ear)	J. Birthplace Country)	e (State or Foreign
	Director		Usual Residence of Decedent 1 ☒ M 2 ☐ F	86 Yrs.			10/03/19		China	a
	and show	ř	10a. State 10b. County	10c. City, Town or Loc	cation	-				Inside City Limits
	Maryl 28a-f otifie	irec	Maryland Wicomico	Salisbur						1 XYes 2 No
	with the 23a or ist be n	Funeral Director	10e. Street and Number 404 Viewfield Drive		10f. Zip Code 2180	4	10	g. Citizen of What USA	at Country?	?
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21215-0036	ould be filed within 72 hours after death with the Maryland d Mental hygiene. marked other than "natural", or items 23a or 28a-f show marke other than "natural" are most be notified at matic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 X Married 1 ☐ Yes 2 1 If Yes, Give Year or Dates	₹ No	☐ Yes 2 X No				Asiar	
15-0	72 hou "natu edica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give A	lent's Usual Occup	during most of work	ing 10	6b. Kind of Busi	ness/Indust	try
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pue;	e filed v ntal Hyg ed othe event,	To Be	17. Father's Name (First, Middle, Last) Chih-rei Sun			18. Mother's Nam	e (First, Middle, Ma	iden Surname)		
Maryland	an is		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rura	l Route Number, C	ity or Town, Stat	te, Zip Code	ie)
d)	and 2		Lewis Sun/Son 20a. Method of Disposition	20b. Place of Dispos		iff Rd.,		Oc. Location - C		, State
Baltimore,	permit. Page 1.8 Department of I Important: If Ite any Injury or ot		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from Sta	salisbury	cremator or other place of the control of the contr	ry 10/4	/2011	Salisbu	ıry, N	MD
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Division of Vital Records, P.O.	Physician: The law requires that the death cer this certificate has been signed by the attendi gral director, page 2 should be detached for use	ed by	Part II, Other significant conditions continuum to death							oly 4 🗆 Unknown
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Re	: The licate h						perform 1 Yes 2	No 1	Yes 2	□ No
/ital	sician certif lirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	atient 2 ER/Outpatier	Oth	lace of Death (Chec	ome 5 🔀 Residen	ce 6 Other	(Specify)	
of/	ng Phy fter this meral c	ite: To	27, Manner of Death 28a. Date of in		28c. Injur work	y at k?	28d. Describe how			
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Dixi	tal or A s after al Direct ed in b		4 - Homiciae determined building,	etc. (Specify)			City or Town,	State)		
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best 2 Medical Examiner: On the basis of 3 Certifying Nurse Practitioner: To	f examination and/or invest	tigation, in my opini	on, death occurred a	t the time, date and	place, and due t	o the cause	e(s) and manner stated.
	To the within To the Compl	Σ	only one) 3 Certifying Nurse Practitioner: 10 29b. Signature and title of certifier	ele pestormy knowledge,	29c. Licens			d. Date signed (
			* Fland Comment Co	-N'	Kege	2500		blober	3,8	2011
	10		30. Name and address of person who completed cause of Jeanra redberg CRWP 1.	death (Item 23a) (Type, F	Print)	SALLEGALLE	4 MO	21006	1	
	Stat	e	31. Date filed (Month, Day, Year) 32. Aegis	trar's Signature	SIOTIOF C	JAU BOU	4 1010	~100	·	
	Registra		OCT 0 6 2011	us A. So	who					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia	an/	Decedent's Name (First, Mid								2. Date of De Month	ath Da	ay	Year	3. Time of De	ath
	Medi	cal	Frank Jerom					T			Octob)11	6:45	\mathbf{A}^{M}
	Examir	ner	4a. Facility Name (if not institut					4b. City, Town, o				40	County o		_	
	Funeral		Wicomico 5. Social Security Number	6. Sex			last birthday		If Under	24 Hrs.	8. Date of Bir		Wice	9. Birthp	lace (State or Fo	oreign
	Director		221-22-3504	1 ₹	M 2 □ F	7	5 Yrs.	Months Days	Hours	Min.	Jan. 22	y, Year)	36	Mary	land	
	d ow t		Usual Residence of Decedent 10a. State 10b. Cou	nh.		100.0	City, Town or L	- onti- n						- 1	od. Inside City L	lan ita
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	he Ma or 28; notif	Dir.	MD Wic 10e. Street and Number	omico	1		alisbu	10f. Zip Code				10a. C	itizen of W	hat Coun		
	with t	Funeral Director	8525 N. West	Road				2180	1			U.	S.A.			
	leath items er mu	E E	11. Marital Status		12. Was Deced	0	J.S. 13	Was Decedent of H If Yes, specify Cuba	lispanic Ori	gin? (Spec	cify Yes or No-		14. Race			
36	", or amin	þ	1 Never Married 2 X N		1 X Yes If Yes, Give	2 □ No 👢	954-	1 ☐ Yes 2 🛣 No			iloaii, etc.j		Specify:	, White, e		
Ş	ours a atural	Completed by	3 Widowed 4 Divord	edent's Edu	Year or Dat	es. I	962	edent's Usual Occup				1 400 1			ite	
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55	within giene. er tha		Elementary/Seconday (0-12	2)	College (1-4	4 or 5+)		oduction				tu	bing	comp	any	
- P	al Hy d oth		17. Father's Name (First, Middl	e, Last)							(First, Middle,	Maiden	Surname)			
S S	Ment Ment arke	욘	Carl Steining	er							ubank					
FANK Sennings Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relation					ling Address (Street	_						ode)	
e,	and 2 Healt em 2 ther		Alice R. Stei 20a. Method of Disposition	ninge	r (W	ife)		5 N. West	Road		alisbur _{ate}	_	ocation - 0	1801	an State	
More	age 1 int of t: If it		1 🖾 Burial 2 🗆 Cremati		lemoval from S	State	cemetery, cre	matory or other plac	· :U	ct. 6	, 2011			-		
E	artme ortan injun		4 Donation 5 Other 21. Signature of Funeral Service		9	[Sp:		11 Memory 2. Name and Addre	ss of Facilit	hv		r	ledro	II, Ma	aryland	
B	permit Depar Impor any in		Dinush	outr	1 101130	11.		Short Fu	neral	Hom	e eet De	elma	r, DE	19	940	
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.	Physician/		Immediate Cause (Final disease or condition	st only one	cadse on eac	ii iii e.	Dem	ENTIF	, 1						Onset and Dea	
-	Medical Examiner	Ш	resulting in death)	C a	Due to (o	r as a consec	<u> </u>	CVVIII	<i></i>					\top		
	LAdillilei	<u>.</u>	Sequentially list conditions,	b	. —									4		
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09	ate be executed hysician and the burial-transit	ical		La												
6876	ificate ig phy as the		IF FEMALE:													
ő ×	eath certificat attending ph I for use as th	an/l	23b. Was decedent pregnant in the past 12 months?	23	Bc. If yes, outco	ome of pregr irth 2 🗆 Fe	nancy tal death 3	Ectopic pregnanc	су				23d. Date			
Вох	deat the at ned fo	Physician/Me	1 Yes 2 No		4 🔲 Pregna 9 🔲 Unkno	ant at time of	f death 5	Other (specify)					Mon	th	Day Yea	r
P.O.	law requires that the de has been signed by the pe 2 should be detached		Part II. Other significant cond	litions con	tributing to dea	ath but not re	sulting in the	underlying cause gi	ven in Part	1.	23e. Did to	obacco	use contrib	oute to the	e cause of deat	h?
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ord	requ been shoul	ete									24a. Was	an	24b. W	ere autop	sy findings avai	ilable
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<u>=</u>	an: The tifficat tor, pa	Be C	25. Was case referred to medic	al				26. PI	ace of Deat	th <i>Check</i>	1 Yes	2 LM N	10 1	Yes	2 LLPINO	
ζ.	nysici iis cer direc	10 B	examiner? 1 Yes 2 No	Ho	ospital: 1 □ Ir	npatient 2] ER/Outpation	ent 3 DOA Oth	er: 4 Nu	ursing Hor	ne 5 🗆 Resid	dence (6 🗆 Other	(Specify)		
Division of Vital Records,	ng Ph fter th meral	ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pen	ndina	28a. Date of (Month	f Injury , Day, Year)	28b. Time of injury	work	y at </th <th>2</th> <th>8d. Describe h</th> <th></th> <th></th> <th></th> <th>-</th> <th></th>	2	8d. Describe h				-	
ion	tendii leath. tor: A the fu	ific	2 Accident Inve	stigation			<u> </u>		Yes 2 🗆							
Κį	or At after o Direct in by	Certificate:		ermined	28e. Place o building	of Injury - At h g, etc. (Speci	nome, farm, st fy)	reet, factory, office		2	8f. Location (8 City or Tow			or Rural	Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.		29a. Certifier 1 Certify	ino Physic	ian. To the be	st of my knov	vledge, death	occured at the time	. date and i	place, and	due to the ca	use(s) a	nd manner	as stated	i.	
	e Hos 124 h e Fun e Fun	Medical	(Check 2 Medica	al Examine	er: On the basis	of examination	on and/or inve	stigation, in my opinion death occurred at the	on, death oc	curred at	the time, date a	and place	e, and due	to the cau	se(s) and manne	r stated.
	To the Comp		29b. Signature and title of certi					29c. License					ate signed			
	. < C		1/1/11/11	M	an	Vi		160	5/5			10	7/3/	//		
	BIVA		30. Name and address of person		-								, ,	7.	01007	
			Mahesha T					.0 Easte	rnsh	ore	Dr Sa	lis	bury	MD	21804	
	Stat	e	31. Date filed (Month, Day, Year	C 200	32. 100	gistrar's Sign	acure	1								

DHMH 17 Rev 7/2009

Physicia	nn/	For State Registrar 1. Decedent's Name Gilbert	(First, Middle, L	State of N		d / Depa		f Health		lental Hy	giene Reg. No. 2	2011 Year	3 4 0 5 2 3. Time of Death
Medic Examin		4a. Facility Name (if r	not institution, g	ive street and number)		2. 6	4b. City, Towr			DETOBE		2011 ounty of Death	•
Funeral Director		# NINSULA 5. Social Security Nul 219-36-565	mber 6	1	96 (In yrs. la 71	ast birthday) Yrs.	If Under 1 Ye Months Da			8. Date of Bir (Month, Da	y, Year)	9. Birth Cour	place (State or Foreign
yland -f show ed at	ctor	,	10b. County		10c. Cit	y, Town or Loc							10d. Inside City Limits 1
th the Mar 3a or 28a t be notifi	Funeral Director	Maryland 10e. Street and Num				Salisk	10f. Zip Cod	L804				n of What Cou	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Decedent Armed Forces 1 Yes 2	?	li li		f Hispanic Or uban, Mexica	an, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	etc.
72 hours an "natura Medical E	Completed	(Spec	15. Decedent's cify only highest	grade completed)		(Give I	lent's Usual Oc ind of work do O NOT use retir	ne during mo:	st of work	ing		of Business/Ir	
be filed within antal Hygiene. ked other tha c event, the I	To Be Co	Elementary/Secor 10 17. Father's Name (Fither)	īrst, Middle, Las	College (1-4 or	5+)		ping re	ceivin 18. Moti	her's Nam	e (First, Middle,			nufacturing
d 2 should alth and Me 1 27 is mar er traumati		19a. Informant's Nar Nancy Sm	me/Relationship							Boute Number			Code)
Page 1 an ment of He tant: If item		20a. Method of Dispo 1 X Burial 2 4 Donation	Cremation 3	Removal from Statectify)	e Wi	Place of Disponentery, crem COMICO Park	sition (Name of natory or other Memori	alace)	10/6,	Date /2011		tion - City or T	
Depart Import any in		21. Signature of Fund	eral Service Lice	onsee	CFS		olToway Ol Snow	Funer Hill	al Ho Rd.,	ome Pro: Salisb	fessicury, M	onal As MD 2180	sociation 4
Physician/ Medical Examiner		23a. Part 1. Enter th shock, or heart Immediate Cause (F disease or condition resulting in death)	t failure. List onl inal	omplications that cause y one cause on each li a. Due to (or as	ne. 5 <u>516</u>	A +10	withe mode of a		`		rest,		Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit	dical Examiner	Sequentially list con if any, leading to imr cause. Enter Underly Cause (Disease or ir that initiated events resulting in death) Li	mediate ying njury	b. Due to (or as									
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. Within 24 hours after death. Complete Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the beautified in the funeral director.	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant g ☐ Unknowr	at time of a	al death 3 🗌	Ectopic pregr Other (specify				230	d. Date of deli Month	very Day Year
ires that the signed by do be deta	d by Pi	Part II. Other signific	cant conditions	Pancrea	but not res	ulting in the u	nderlying cause	given in Par	t I.	23e. Did t			the cause of death?
ne law requ e has been age 2 shou	omplete	(COPD								psy	prior to c death?	opsy findings available ompletion of cause of
sician: The law i certificate has b lirector, page 2 s	Be C	25. Was case referred examiner?	d to medical				26	. Place of De	ath (Chec	1 L Yes k only one)	2 LJ No	1 L Yes	2 No
Physic this ce ral dire	욘	1 Yes 2 2		Hospital:		ER/Outpatier	t 3 L DOA	Other: 4 🗌 t		ome 5 Resi			(y)
Attending death. ctor: After	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending Investigat 6 Could no	(Month, D	ay, Year)	injury	M 1	/ork?	- 1	28d. Describe			al Route Number,
spital or the control of the control		4 ☐ Homicide 29a. Certifier 1	determine	building, e	of my know	edge, death c	occurred at the	time, date an	d place, a	City or Tou	wn, State) ause(s) and	manner as sta	ted.
he Hoo iin 24 h he Fur	Medical	(Check 2	Medical Exa	miner: On the basis of urse Practitioner: To	examination	n and/or invest	igation, in my o	oinion, death o	occurred a	t the time, date	and place, ar	nd due to the c	ause(s) and manner state
Nith To 1		29b. Signature and ti	4 1	elento				29/C	5			signed (Month)	
ne				o completed cause of leston, MD		23a) (Type, P	ord St.	, Sali	sbur	y, MD 2	1804		
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 per FH G926 4/27/12 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mont **Physician** 9:25PM /Medical 4) City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner 11974 TERL 9. 7. Age (In vrs last birthday **Funeral** Months Min. Davs Hours 1 M 2 □ F Director Usual Residence of Decedent hours after death with the Maryland City, Town or Location 10d. Inside City Limits 10a, State 10h County 10c. 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it it wild the 18 permittee must be notified as any injury or other traumatic event, it in "ledged Exam he must be notified as 1 ☐ Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip (Tの 4:02のm 10-6-201/ Baltimore, Maryland 21215-0036 3 Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) . Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ဂ္ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20c. Location - City or 20b. Place of Disposition (Name of cemetery, crematory or other p Date Town, State 20a. Method of Disposition matory or other place) 1 Burial 2 Cremation 3 Removal from State TAYLOR 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fox Funcal Home M. 0 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 45CVD /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): signed by the attending physician P.O. Box 68760 Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director, i 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MB 21804 1415 SAUSBURY sheet 5- DIVISION N77289 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar OCI

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 5, Day 2011 Year Physician/ 6:50 Рм Muriel I. Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Apex Health of Silver Spring 8. Date of Birth (Month, Day, Year) Dec. 24, 1919 . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Months Days Hours New York Director Dec. 057-16-4502 Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 XYes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20019 162 35th Street NE within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates an "natural", Medical Exar Specify: Black 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the Government Secretary traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sarah Ann Degeneste Julius Runnells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Smith - Son 162 35th Street NE Washington, DC 20019 1 and 2 s of Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Clinton, Maryland Lee Crematory Signature of Funeral Service Licepe 22. Name and Address of Facility Stewart Funeral Home, Inc. 5 Mi 2 WW Road NE Washington, DC Benning 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit or Attending Physician: The law requires that the death certificate be executed that initiated events й Due to (or as a consequence of): resulting in death) Last ng physician a as the burial-I Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Day signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Adult failure to thrive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension certificate has be lirector, page 2 s performed? Yes 2 No 1 Yes 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ■ Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier how dry October 7, 2011 D43121

Registrar

DHMH 17 Rev 7/2009

Burtonsville, Md.

20866

15216 Dino Drive

30. Name and address of person who despleted cause of death (Item 23a) (Type, Print)

MD

Nurul Chowdhury,

11-0/439 State of Maryland / Department of Health and Mental Hygiene Alexander Teachout 1- For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day October 4, 2011 1447 hrs Teachout Medical Examiner Alexander 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring 12304 Clement Lane If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Min. Months | Days Country) CA **Director** 20 March 4, 1991 603-60-6768 **孫 M 2 F** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 X No If item 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at once. Silver Spring MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12304 Clement Lane 20902 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No 1 Yes Specify: White 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: 3 Widowed ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nati College (1-4 or 5+) Elementary/Secondary (0-12) College Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Teachout Anna M. Fink 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12304 Clement Lane, Silver Spring, MD 20902 Robert Teachout/Father 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 12 X Cremation 3 Removal from State Oct. 6, 201 ĭ Metropolitan Crematory Alexandria, VA 4 Donation 5 Other Specify 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090

Approximate Interval 21. Sign of Fu er I S ice License Approximate Interval Between Onset and 23. Part I. Ent. the discase, o' com lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial - transit Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ğ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy death? performed' 2 No ✓ Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes ٩ 28d. Describe how injury occurred 28a. Date of Injury FOUND: 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: Subject shot self FOUND: 1 Natural 1 Yes 2 ✔ No Pending completely filled in by the Oct 4, 2011 1443 hrs Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 12304 Clement Lane, Silver Spring, MD determined (Specify) Single Family Home 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. October 5, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Patricia Aronica-Pollak MD. 31. Date filed (Month, Daye Year) 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) TOBER 201 Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** MONTGOMER HOSPITAL DLNE CHENERAL MONTGOMERY Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs 7. Age (In yrs. last birthday) If Under **Funeral** Days Months 213-56-6906 1 □ M 2X F 04/15/1946 DC Director Usual Residence of Deced 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Silver Spring Montgamery MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 20904 Funeral 531 Randolph Road, #139A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc 1 Yes 2 X No If Yes, Give Year or Dates. 1X Never Married 2 ☐ Married þ Specify: Black 1 Yes 2 X No Specify: 3altimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Marriott Corporation Cook 11th 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Bettie E. Green Ernest O. Thornton, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3532 Cherry Hill Court, Beltsville, MD 20705 Doretha M. Thornton/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from St Bladensburg, MD Lincoln Cemetery 10/14/2011 Ft 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home of Funeral Service Licen Signatur 246 N. Washington St. Rockville, MD 20850 not enter the mode of dying, such as cardiac or respiratory arrest Approximate ations that caused the death. Do cause on each line. Interval Between Onset and Death 23a. Part 1. Enter the dise; shock, or heart failure Immediate Cause (Final disease or condition resulting in death) JAGE Physician/ Medical Due to (or as a con uence of **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine e burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Month in the past 12 months?

1 Yes 2 No Pregnant at time of death ed by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b 1 Ves 2 No 3 Probably 4 Unknown ARTERY Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES autopsy has 2 1 No 1 Yes To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate by 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 은 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 5 Pending 1 Natural Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCTOBER 6,2011 D59418

State Registrar DHMH 17 Rev 06-2011

5

MONTGOMERY GENERAL HOSPITAL

Dewunderun

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADEWUNMI

OLUYEMISI

1 1 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 7 Katherine Elizabeth Underwood 2011 10:01 A 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours Min 1 🗆 M 2 💢 F 726 09 2957 95 July 8, 1916 Washington DC Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No P.G Accokeek 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 15758 Livingston Road 20607 United Stated 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 X No 1 ☐ res . If Yes, Give 1 ☐ Yes 2 ☐ No Specify. Specify. 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9th College (1-4 or 5+) Own Hone Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Fielder Means Elsie Marie Summers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Etter (Daughter) <u> 15758 Livingston Road, Accokeek. MD 20607</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

XXBurial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Oct 12, 2011 Clinton, MD Resurrection Cemetery 22. Name and Address of Facility ure of Funeral Service Licen Sign mois 1 Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clipton, MD 20735 23a. Par 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)

Physician/ Medical **Examiner**

attending physician a for use as the burial-

ed by the a

signed | d be det

has e 2 page

within 24 hours after death.

To the Funeral Director: After this certifict completely filled in by the funeral director.

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

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Examine

Physician/Medical

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Completed

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Certificate:

Medical

29a. Certifier

Examiner

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

d 2 should be filed with alth and Mental Hygien. 27 is marked other th

permit. Page 1 and 2 si Department of Health ai Important: If item 27 is any injury or are

Maryland 21215-0036

Baltimore,

Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

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oplications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardiac or respirato	Interval Betwee	
Due to (or a consequence of):	GROTIC CARDIOUA	SWAN TUSALE	>
Due to (or as a consequence of):		YEA4	3
Due to (or as a consequence of):			

IF FEMALE

res, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Pregnant at time of death 9 Unknown

3	Ectopic pregnancy
5	Other (specify)

23d. Date of delivery Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e.	e. Did tobacco use contribute to the cause of death?								
	1 🗌 Yes	2 [No	3 Probably	4 Unknown				
24a	Was an		24b.	Were autopsy fin	dings available				

Year

26. Place of Death (Check on

28a. Da

1 🗌 Yes 2 🕻	No 3 Pro	bably 4 Unknow
24a. Was an autopsy performed? 1 □ Yes 2 🛣No	24b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of 2 No

25. Was case referred to medical examiner? Hospital: 2 X No 27. Manner of Death

🗌 Inpatient 2 🄀	ER/Outpatient	3 🗆 1	DOA
te of injury onth, Day, Year)	28b. Time of injury	M	28c.

k onl	y one)		
ome	5 Residence	6 Other (Specify)	
28d.	Describe how inj	ury occurred	

E CENTER WALROUF, And TOLOOZ

24

1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide determined

(Month, Day, Year)	injury	M	work?	2 🗆 No
28e. Place of Injury - At he building, etc. (Specify		, facto	ory, office	

【 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other:

4 Nursing Home

Cify or Town, State)	

	only one)	3 □ C	ertifying	Nurse	Practition	er: To the	best of m
9b.	Signature	and title of	f certifier				
		111					

ny knowledge, death	occurred at the time, date and place, and due to	the
	29c. License number	29

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the cause(s) and mainer as stated.	
29d. Date signed (Month, Day, Year)	1105

State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physici	anl	Registrar 1. Decedent's Name (First, Middle)	e.Last)	CE		Dealli			2. Date o	Reg.	No.	<u> </u>	3. Time of Death
Medical Exami			Hong Tran	g Tracy	/ Vu				Month Octob	per 8, 2	ay Year 1011		1125 hrs
		4a. Facility Name (if not institutio	. •	ımber)		•		ocation of E			4c. County of		
		5401 Westbard Avenu		7		Bethes		Г <u>и</u>	uu loo	(D: #	Montgom	•	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.	•	If Under Months	_	If Under 2 Hours	Min			Foreign	hplace (State or
		220-47-4943 Usual Residence of Decedent	1 M 2 X F	35	Yr:	S.			Jui	1e 23	3,1976	Cou	untry) Vietnam
any		10a. State 10b. County		10c. City	y, Town or Loca	tion	-						10d. Inside City Limits
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	by Fu	3 Widowed 4 Div	1 Yes orced If Yes, Give Yes or Dates:		1	Yes 2	No	specify:			Specify:		Asian
hours after natural", Examiner	ed b	15. Decedent's Education (Spe-	cify only highest gra			nt's Usual C			d of work done e retired)	16	6b. Kind of Bus	ness/Ir	ndustry
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5-0036 lied within 72 hours. Hygiene. I ather thao "natur:	Completed	17. Father's Name (First, Middle,		=		whet			Name (First, Mi	ddle, Mai		m	Sacon
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Baltimore Department of He Important: If its njury or other t		1 X Burial 2 Cremation		om State	crematory or of	ther place)							
Baltimo permit. Page Department o Important: injury or oth		Donation 5 Other Sci 21. Signature of Funeral Service	o⊪esee		22. 1	1eave/ Name and A	ddress o	n. I	10/11/2	inala	Li Euro	Spr	ing, MD Home, Inc.
Dep Der C		23a. Part I. Enter the disease, or		M0124	1 118	800 Ne	w Ho	umpshi	ire Ave	., S.	ilver S	pri	ng. MD 20904
Physician /M		23a. Part I. Enter the disease, or failure. List only one cause	complications that con each line.	aused the deat	h. Do not enter t	the mode of	dying, sı	uch as card	liac or respirato	ory arrest,	, shock, or hear	t	Approximate Interval Between Onset and
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Box 68760, e death certificate by the attending physic ed for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in th past 12 months?		outcome of pre- irth		etal death	3	Ectopic pr	egnancy		23d. Date of d Month	lelivery D:	ay Year
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C the de by the ached f	Phy	Part II. Other significant conditi	9011011		resulting in the	underlying o	ause giv	ren in Part I	. 23e.	Did toba	cco use contrib	ute to t	he cause of death?
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Division of Vital Records, talor Attending Physician: The law requiring after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be a by the funeral director, page 2 should be a by the funeral director.	Completed								24a.	Was an autopsy			opsy findings available
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Division of the control of the contr	Certification:		not be	Multi-Fam		-,,		3 ,	or To	own, State			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		29a. Certifier 1 Certifying Pt	ysician: To the bes	at of my knowle	dge, death occu								
To the within Trath	edical	one) 2 Medical Exam	and manner s	of examination tated.	and/or investiga				red at the time,				
10	Ž	29b Signatule and title of certifie	^				License				9d. Date signed October 9, 2		tn, Day, Year)
• ·	ŀ	30. Name and address of person	who completed com	se of death /ltor	n 23a\		J.O.IVI						
			ssistant Medica	,		altimore	Street,	Baltimo	re, MD 212	23			
	ate	31. Date filed (Month, Day, Year)	111 3. Re	egistrar's Signa	ure Jav	11							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast 2. Date of Death Physician/ rent 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LLC inton 6. Sex 1 M 2 □ F Year If Under 24 Hrs. Davs Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (Sta **Funeral** (Month, Pay, Year 54 Director 62-980 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County ä 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Yes 2 No Clinton bryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a other traumatic event, the Medical Examiner must Reilly 4808 20735 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JAMES MAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oteven 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 🕱 Cremation 3 🗀 Removal from State 5 injury 4 ☐ Donation 5 ☐ Other (Specify) 10-15-11 Juneral Service Ucensee 22. Name and Address of Facility any M) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ CARDOMYSPATHN (DILATIO disease or condition Medical resulting in death) Examiner 17,001 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and s the burial-transit requires that the death certificate be executed CIRMINOSIS Exa Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Yes 2 ☐ No ed by the a g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by detail 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown been: 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? has page death? certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 2 No Hospital Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 🔲 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending After injury 5 Pending 1 ☐ Yes 2 ☐ No hin 24 hours after death. **the Funeral Director:** A Accident М Investigation the 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

reson who completed cause of death (Item 23a) (Type, Print)

wark!

Wehreman , Philip altimore Maryland 21215-0036

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			_ State	of Maryland		artment of H tificate of D			giene Reg. No	2011	34060
		•	1. Decedent's Name (First, Middle, Last)		001	tinoate of B	Joann	2. Date of Dea	ath		3. Time of Death
	Physicia Medic		Philip Gibson Wehrman					Octobe		0,2011	7:40 PM
	Examin	er	4a. Facility Name (if not institution, give street and n Doctors Community Hospit			4b. City, Town, or Lanham	Location of Death			. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti	h	9. Birtl	nplace (State or Foreign
H	Director		224 72 4526	52	Yrs.			April 3	0, 1	959 Mary	land
	rland f show	tor	10a. State 10b. County	10c. City,	Town or Loc	cation					10d. Inside City Limits
	e Mary r 28a-	Director	Maryland Prince George's 10e. Street and Number	For	estvill	10f. Zip Code			10a C	itizen of What Co	1 Yes 2 X No
	with th	Funeral	3703 Nearbrook Ave			2074	47			ited State	
	death items		11. Marital Status 12. Was De Armed	ecedent Ever in U.S. Forces?	13. V	Vas Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White	
030	2 hours after death with the Maryland "natural", or items 23a or 28a-f show solical Examiner must be notified at	d by	1 ☐ Never Married 2 【 Married 1 ☐ Yes, 6 1 Yes, 6 Year or	es 2 No Give 1983-1 Dates. 1983-1	.991	Yes 2 X No	Specify:			Specify: W	hite
215-0036	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho svent, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade complete	ed)	(Give I		ation furing most of work	ing	16b. l	Kind of Business I	ndustry
7272	vithin 72 hour liene. er than "natul the Medical	Com	Elementary/Seconday (0-12) College	(1-4 or 5+)	Carpe	o NOT use retired) enter			Con	struction	
nd 2	e filed wil tal Hygie ed other event, th	Be c	17. Father's Name (First, Middle, Last)		-		18. Mother's Nam		Maiden	Surname)	
Maryland	2 should be fill th and Mental 27 is marked of traumatic ever	Jo	Philip William Wehman 19a. Informant's Name/Relationship (Type, Print)		40b M-35	- Address (Ctrast	Constance and Number or Rura		r City o	r Town State Zin	Codel
	12 shoalth an 27 is r	ì	Beverley Wiese (Wife)			Ave. Fores				
Baltimore,	ge 1 and it of Heal if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 XXCremation 3 ☐ Removal for	20b. Pla	ace of Dispo	sition (Name of natory or other plac		Date		ocation - City or	Town, State
Ĩ	permit. Page Department of Important; If any injury or once.		4 Donation 5 Other (Specify)	Lee (Cremato	ry	10/14/			Clinton, M	
Ra	permi Depa Impo any ii		21. Signature of Funeral-Bervice Licensee	MO15.	3 3 ²²	erry Road.	Clinton, M	Funeral I D 20735	Home,	,inc 66330.	ld Alexandria
			23a. Plart 1. Enter the disease, or complications the ship k, or heart failure. List only one cause on	at caused the death. ea. h line.					rest,		Approximate Interval Between
- (Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	tavanc		Gast	roines	stinal	1	ymor	Onset and Death
	Examiner		Due	to (or as a conseque	4PL	tens	100				
	n .≅	Examiner	cause. Enter Underlying	to (or as a conseque	ence of):	a bechi	. 1 1	1000			
	executed an and rial-transit	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due	to (or as a conseque	ence of):	יווי כאוי	1915	17 66	(11)	} 	
Š	te be e	dical	d	Ar	100	119					
09/89	res that the death certificate be signed by the attending physici d be detached for use as the bu	Physician/Medica	IF FEMALE: 23c. If yes,	outcome of pregnan	cy					23d. Date of de	livery
ROX	leath c e atten d for u	siciar	in the past 12 months?	ive Birth 2 Fetal regnant at time of de nknown	death 3	Ctopic pregnand Other (specify)	СУ			Month	Day Year
J.	at the c d by th etache	Phys	9 Unknown Part II. Other significant conditions contributing t		ilting in the u	underlying cause giv	ven in Part I.	23e. Did to	obacco	use contribute to	the cause of death?
S,	The law requires that the arte has been signed by the page 2 should be detach	d by	•								robably 4 Unknown
örd	w requ	Completed						24a. Was	psy	prior to	topsy findings available completion of cause of
Ř	sician: The law require certificate has been si irector, page 2 should l							1 L Yes	2 (1)	death?	s 2 🗆 No
Vital Records,	rsician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 🗆 E	=R/Outpatie	Oth	er: 4 Nursing H		dence	6 Other (Spec	ify)
o	ng Phy fter thi		27. Manner of Death Natural 5 Pending 28a. Death		28b. Time of injury	f 28c. Injur work	y at k?	28d. Describe			
Sion	Attendi death. ctor: A y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ace of Injury - At hon	ne, farm, str		Yes 2 □ No	28f. Location (Street a	nd Number or Ru	ral Route Number,
Division of	tal or Ars after al Direction bed in b	Sel	4 🗆 Homiciae determined bu	illding, etc. (Specify)				City or Tov			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	ledical	29a. Certifier (Check only one) 2	basis of examination	and/or inves	stigation, in my opinic	on, death occurred a	at the time, date a	and plac	ce, and due to the	cause(s) and manner state
	To the within To the comple	Σ	only one) 3 ☐ Certifying Nurse Praction 29b. Signature and title of certifier	er: To the best of my	Knowleage,	29c. Licens	e number			ate signed (Mont	
	Ní.		Masch	ueile	1		<u>5250</u>	0	ı	0-11	- 2011
ナ	1		30. Name and address of person who completed of	ause of death (Item	23a) (Type, I	Print)	Luck R	OND. L	NN	HAM M	10 20706
	Stat			2. Registrar's Signatu	ure			-			
	Registra	ar	001 10 2011 /2	Brace for	1. 1636	ar Mand					

DHMH 17 Rev 7/2009

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			For State State Registrar	of Maryland / L	Certificate of D			g. No. O	31.061
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Septembe	Day Year	3. Time of Death
~ ~	Medic Examin	al	Yu-Ting Wu 4a. Facility Name (if not institution, give street and no	umber)	4b. City, Town, or	Location of Death	Septembe	er 29 201 4c. County of Deat	
	LAGIIIII		Casey House		Rockvil	1e		Montgom	
K	Funeral Director		5. Social Security Number 226-82-4864 6. Sex 1 □ X M 2 □ F	7. Age (In yrs. last birth	Months Days If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 22	'ear) Co	thplace (State or Foreign untry) hina
	/land f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	e Mary r 28a- notifie	Director	MD Montgomery 10e. Street and Number	Roc	ckville		10	lg. Citizen of What Co	
	with th	Funeral	5829 Mossrock Drive			852		USA	ŕ
336	is filed within 72 hours after death with the Maryland tal Hygiene. It al Hygiene. It of ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ह्य	Armed		13. Was Decedent of His If Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	72 hours an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade complete	16a.	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)		ing 1	6b. Kind of Business	Industry
212	ed within Hygiene. other tha ent, the l		4		kecutive Che			Restaura	nteur
land	ould be filed of Mental H marked of matic even	To Be	17. Father's Name (First, Middle, Last) Yen-Tzi Wu			18. Mother's Nam Zhou-T:	e (First, Middle, Ma si Wu	uiden Surname)	
Maryland	permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic evenones.		19a. Informant's Name/Relationship (Type, Print) Anna Chow/Daughter		. Mailing Address (Street a 829 Mossrock				
Baltimore,	e 1 and t of Hea If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro		Disposition (Name of y, crematory or other place	9)		0c. Location - City or	
<u>ti</u> m	nit. Pag artmen ortant: injury		4 Donation 5 Other (Specify)	Gate	of Heaven				ing, Maryland rial Chapels
Ba	Depa Imp any once	1	> magreenhad		1170 Rockv	ille Pik	e, Rockvi	lle, Mary	land 20852
	Medical Examiner	ner	Sequentially list conditions.	each line.	l Carcinoma	, such as cardiac (or respiratory arres	,	Approximate Interval Between Onset and Death
092	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-traction.	ledical Examiner	cause. Enter Underlying Cause (breases or impury that initiated events resulting in death) Last C. Due	o (or as a consequence o	of):				
. Box 68	that the death certificated by the attending podetached for use as	Physician/M	in the past 12 months?	outcome of pregnancy ve Birth 2 Fetal death egnant at time of death oknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	У		23d. Date of de Month	Blivery Day Year
s, P.O.	ires that t signed b d be deta	by	Part II. Other significant conditions contributing to	death but not resulting in	n the underlying cause giv	en in Part I.			o the cause of death? Probably 4X Unknown
of Vital Records,	sician: The law require certificate has been s irector, page 2 should	Completed					24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
/ital	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2 ☐ ER/Ou	Oth	ace of Death (Chec		nce 6X Other (Spe	cif ,Casey House
0	Attending Phy ir death. ector: After this by the funeral d		27. Manner of Death 28a. Da	te of injury 28b. T	ime of 28c. Injury	at	28d. Describe hov		
Division	ital or Attending urs after death. ral Director: After led in by the fune	al Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pla	ce of Injury - At home, far Ilding, etc. (Specify)			City or Town,		
	To the Hospital or A within 24 hours after To the Funeral Direct T	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the 3 Certifying Nurse Practions	pasis of examination and/o	r investigation, in my opinio	n, death occurred a	t the time, date and	l place, and due to the	cause(s) and manner stated.
	vithir to the	2	29b. Signature and title of certifier		29c. License			d. Date signed (Mon	
			Bolyn	() II II II OS) T	D00606			September	30, 2011
			30. Name and address of person who completed c Joseph C. Bindu, MD 11	60 Vamum Sti	reet, Washin		20017		
	Sta Registr		31. Date filed (Month, Day, Year)	. Registrar's Signature	harles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8 Medical 4b. City, Town, or Location of Death give street and number) 4c. County of Death 4a. Facility Name & not institution **Examiner** 305 121005 Y1 729 3 har. a.s. 8. Date of Birth 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. 1 🛛 M 2 🗆 F Hours 08/08/1957 216-68-1823 54 **Director** or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** be notified 1X Yes 2 ☐ No Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a USA 14134 Castle Blvd., 20904 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 □ Divorced **Black** event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ABC Imaging 12th CADD Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joan Lewis Sylvester M. Webb, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 22 Standard Court, Gaithersburg, MD 20877 Vanessa Hill/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Argent Cremation Svc 10/14/2011 Hanover, MD 4 Donation 5 Other (Specific 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between tions that caused the death not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the di Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and proposed in the funeral director, page 2 should be detached for the best of the funeral director, page 2 should be detached for the best of the b Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE E≅MALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 🔲 Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 🗌 Yes 2 🔲 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗌 No 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d, Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number Sionature and title of cer mooms Date filed (Month, Day, Year, 32. Registra State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ise Type								-			jible.		
		For State		Stat	e of M	larylan					and N	/lental Hy	gie	ne		0.1	
		Registrar					Ce	rtificat	e of E	Death	_		Reg.	No. 2 [31	1063
Physicia Medic		1. Decedent's Nam	e (First, Middle	, Last)			WA	RD				2. Date of De Month	eath	Day.	Year 2011	3. Time	of Death
Examin	er	4a. Facility Name (if			,			1		Location	of Death			4c. County			
f		Anne Aru 5. Social Security N		edical 6. Sex			ast birthday)	Ann If Unde	apol	1s If Under	24 Hrs.	8. Date of Bir	th	Anne		nde1 hplace (State	or Foreign
Funeral Director		578-36-05 Usual Residence	52	1 □ M 2 🗷		1	Yrs.	Months	Days	Hours	Min.	Feb. 2	4, Yea	1920	S. I	npiace (State intry))akota	or Foreign
aryland a-f show iled at	Director	10a. State	10b. County	-			y, Town or Lo	ocation								10d. Inside	City Limits
or 28	Dir	MD 10e. Street and Nur		e George	es	Bot	vie	10f. Zip	Code			1	10a	. Citizen of	What Co		
with t	Funeral	14997 Hea	1th Cer	nter Dr				20	716				J	U.S.			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marr 3 【☐ Widowed		ried 1 I	Decedent d Forces? Yes 2 \(\overline{\infty}\) , Give or Dates.			Was Deced If Yes, spec	ify Cuba	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		Blad	e - Amer ck, White		
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l be filed v fental Hyg rked othe tic event,	To Be	17. Father's Name (Adam Ste		,								e (First, Middle, y Balce		len Surnam	e)		
should and M is ma		19a. Informant's Na	ame/Relationsl	nip (Type, Print)			19b. Maili	ng Address	(Street a	ınd Numbe	er or Rura	al Route Numbe	er, Cit	y or Town, S	State, Zip	Code)	
nd 2 s ealth m 27		Gary V.		Son			115	Prosp	ect	Dr. U	Jppe	Marlb	orc	, MD	207	774	
Page 1 aunent of Hants If Itel		20a. Method of Disp 1 X Burial 2 4 ☐ Donation	☐ Cremation	3 ☐ Removal	from State	, c	lace of Dispo emetery, crea ional	matory or c	ther plac			Date 11/2011	l			Town, State	
permit. Departn Imports any inju		21. Signature of Fu	neral Service L	idensee	MO1	145						Vol Fun				OC 200	007
		23a. Part I. Enter t	the disease, or	complications to	hat cause	d the deat										Approxim	ate
Physician/ Medical		Immediate Cause (disease or condition resulting in death)	Final	. / /			ANIA	L t	FM	ORR	HP	GE				Interval Bo	d Death
Examiner	J.	Sequentially list co	nditions,	b. —	e to (or as	a consequ	ANIA	type	RTE	-WSC	32					75	425
ecuted and	Examiner	if any, leading to in cause. Enter Under Cause (Disease or that initiated events	rlying injury	c	e to (or as	a consequ	ience of):	,									
@ ≅ .≅	ē	resulting in death) l	Last	d	e to (or as	a consequ	uence of):										
tificat ing ph e as tl	Med	IF FEMALE:		T										1			
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician. To the Funeral Director: After this certificate has been signed by the attending physician for upon place of the funeral director, page 2 should be detached for use as the burian properties of the funeral director, page 2 should be detached for use as the burian properties.	Completed by Physician/Medic	23b. Was decedent in the past 12 r 1 Yes 2-2 9 Unknown	months?	1 _ 4 _	Live Birth	of pregna 2 Feta at time of c	Ideath 3	Ectopic Other (sp		у					ite of del onth	Day	Year
that the	y P	Part II. Other signif	icant condition	^			•	underlying	_		l.	23e. Did t	tobac	co use cont	ribute to	the cause of	death?
uires t n sign	q pa	F	MTI	COMBU	LATE	D	fur	17	FIL	3		1 🗆	Yes	2 € No	3 🗌 Pı	obably 4	Unknown
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in: Th ifficate or, pa	Be C	25. Was case referre	ed to medical						26. Pla	ace of Dea	th (Chec	1 Yes k only one)	2	No	1 ∐ Yes	2 No	
ysicia s cert direct	To B	examiner?	No	Hospital:	1 Thipat	ient 2 🗆	ER/Outpatie	nt 3 🗆 D	Othe	or.		ome 5 \square Resi	dence	e 6 🗆 Oth	er (Spec	fv)	
nding Phy sth. : After thi e funeral		27. Manner of Death 1 Natural 2 Accident	5 Pendir	28a. [Date of injudent	ıry	28b. Time o injury		8c. Injury work	at at		28d. Describe					
al or Atters after degal Directored in by the	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e. F	lace of Injuilding, et	ury - At ho c. (Specify	me, farm, str	reet, factor	, office			28f. Location (City or To			er or Rui	al Route Nun	nber,
n 24 hour n 24 hour ne Funera pletely fill	Medical	(Check 2	Medical E	Physician: To t xaminer: On the Nurse Practiti	e basis of	examination	and/or inves	tigation, in	ny opinic	n, death o	ccurred a	t the time, date	and pl	ace, and du	e to the c	:ause(s) and n	nanner stated.
To the within To the Company of the	-	29b. Signature and		1 2	Jul	han			License		- /			Date signe	d (Month		(
		30. Name and addre	. 1	who completed	cause of	death (Item	23a) (Type, I	Print)	SE	Hwa	A	NNAPOL	15	MO	240)	
Stat	е	31. Date filed (Mont.		011	Ž. Registi	ar's Signa	ure for	20			+					1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34064 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RUTH ELIZABETH SPINDLER WOHLSCHLEGEL Medical OCTOBER 2011 1:55 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death QUEEN ANNE'S COUNTY HOSPICE CENTER CENTREVILLE QUEEN ANNE'S Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 **X**F Months Days Hours Min. NEW JERSEY SEPT. 29. 1927 Director 144-22-5676 84 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Directo 1 🗌 Yes 2 🔀 No CENTREVILLE QUEEN ANNE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 248 COON BOX ROAD 21617 filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ı "natural", or iten edical Examiner ı Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced Specify: WHITE Completed the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** SECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F permit. Page 1 and 2 should be file Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic eve မ LILLIAN NUMMELIN WILLIAM SPINDLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERVIN WOHLSCHLEGEL/ HUSBAND 248 COON BOX ROAD, CENTREVILLE, MD 21617 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OCT. 10, PRINCETON CEMETERY PRINCETON, NJ 2011 Signature of Euperal Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) The. 14/5 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Tause (Disease of Infjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Dav Pregnant at time of death detached g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 2 No Yes 2 No 1 🗌 Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' HOSPICE CENTER Hospital: 1 🗌 Yes 2 🔀 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ♣ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours a Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 To the l 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year) J. Jiwa M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21617

State Registrar pare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:38AM Day 2011 Physician/ JUANITA OCT C. WRIGHT 9 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1 □ M 2**X** F AUG 27 Country) Hours 238 68 2844 **Director** 69 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits MD 1 Ves 2 No P.G. BELTSVILLE 10e. Street and Number ò 10f. Zip Code must be r 10g. Citizen of What Country? 23a Funeral 11409 RHODE ISLAND AVENUE 20705 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 0 ş 1 Never Married 2 Married 2**X** No 1 Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. Specify: BLACK "natural" 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) than ife. DO NOT use retired)
SCHOOL TEACHER Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N D C PUBLIC SCHOOLS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOSEPH CANNON THELMA SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL L. WRIGHT/HUSBAND 11409 RHODE ISLAND AVE BELTSVILLE MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) GREENSBORO, NC 4 ☐ Donation 5 ☐ Other (Specify) GUILFORD MEM. PK. 10/15/11 20010 21. Sign tun of Funeral Service Licenses 22. Name and Address of Facility WATSON F H 3435 14th ST. WASH. N.W. 23a. Part 1 Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death COLON CANCER Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) executed and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Company at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical l a 26. Place of Death (Check only one) Hospital: 2 🗓 No 1 Yes Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 68150 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIRAJ NEJIB 1500 FOREST GLEN ROAD SILVER SPRING MD. MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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11-07646 Harvey Lee Wright Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #State of Maryland & Department of Health and Mental Hygiene

2011 34066

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1620 Wertman Franklin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Country) WV Days 1 🖳 M 2 🗆 F Hours Min Jan 10. 1924 Director 234-26-9576 87 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 13301 Winchester Road SW 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural" 3 XWidowed 4 Divorced WW II white Completed Medical Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) salesman Sears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lottie Crites Ira Wertman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Rt. 5 Box 491 Keyser WV 26726 Patsy Kesecker per. rep 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Duling Cemetery 10/14/2011 WV Kevser tion 5 D Other (Specify) 22. Name and Address of Feculity eral Home, PA nature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part Enter the disease, or complications trial caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No ò Day Year be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available 24a Was an page 2 prior to completion of cause of death? certificate has performed 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 1100 ပ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending s after death.
I Director: Affed in by the fu work? 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ignature 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

12500 Willowbrook Rd. Cumberland, MD a1503

11-07534 Joy Elaine Young

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ October 8, 2011 0234 hrs **Medical Examiner** Joy Elaine Young 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Cecil Elkton Route 273 WB east of Blue Ball Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Pennsy Lvania 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Hours Months Director Country) 2 X F 03/21/1958 1 M 53 176-38-3759 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 1 Yes 2 X No nr items 23a nr 28a-f show Chester West Grove Itimore, MD 21215-0036

iit. Pages I and 2 should be filed within 72 hours after death with the Maryland utment of Health and Mental Hygiene. ordant: If them 27 is marked other than "natural", nr items 23a nr 28s-f sho yor an other transmitic event, the Medical Examiner must be notified at once. Pennsylvanija 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States ō 19390 276 Lewis Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Specify: White <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pharmacy Technician Pharmaceutical 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James A. Trimble Doris Surgeson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William S. Young/Son 257 W. Evergreen Street, West Grove, PA 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, October New Garden Friends Cemetery 1 X Burial 2 Cremation 3 Removal from State 15, 2011 Toughkenamon, PA 4 Other Specify 22. Name and Address of Facility Hicks Home for Funerals, P.A. ature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or complications Physician Between Onset and failure. List only one cause on each line /iviedical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial -The law requires that the death certificate be Records, P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Fetal death Day 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown Į. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown ficate has been s , page 2 should t 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes Yes 2 No 2 No certificate 26.Place of Death (Check only one) Hnspital nr Attending Physician: funeral director, 25. Was case referred to medical Division of Vital Be Other Nursing Home 5 Residence 6 🗸 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes 28a. Date of Injury After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification Driver in vehicular collision Oct 8, 2011 1 Natural 0225 hrs 1 Yes 2 ✓ No Pending Tn the Funeral Director: completely filled in by the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after 3 Suicide Could not be or Town, State) Route 273 W/B east of Blue Ball Road, Elkton, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) (and manner stated 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number October 8, 2011 O.C.M.E. te 30 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State 2 Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ PM Armentrout 20 October eresa Leah Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** The Johns Hookins Hospital Baltimore Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 233-11-2132 49 1 □ M 2 🖁 F Director Yrs Dec. 28, 1961 West Virginia Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director 1 X Yes 2 No Alexandria Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a Funeral 22304 U.S.A. #1412 200 N. Pickett Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🖔 No Black, White, etc. ģ 1 X Never Married 2 Married "natural", or Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) 72 permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetin. Elementary/Secondary (0-12) College (1-4 or 5+) Government Administration Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Frances Marie Chewning William Sherman Armentrout 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13804 Fount Beattie Ct., Centreville, VA 20121 (Brother) Mark Armentrout Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Elkins, WV Elkins Memorial Grdns. 10/25/11 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Tomblyn Funeral Home 45 Randolph Ave., Elkins, WV 26241 m01284 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Pancreatic Onset and Death Immediate Cause (Final Physician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Examine Due to (or as a consequence of) use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last iding physician and Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? 1 Yes 2 No Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate I 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: _2 🗶 No 1 Tes ည 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d, Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Jason E. Michaud MD

26

31. Date filed (Month, Day, Year)

RES - 000

N. Wolfe St Baltimore Maryland 21287

October 20 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State of Ma	aryland /				Mental Hy	giene	Ð	
			State Registrar					tificate of Death		1.0. (0	Reg. No. 20113407		
	Physicia Medic		1. Decedent's Name (F		JOSUE			ARANA		2. Date of De Month		ay Year	3. Time of Death / 21:50 M
	Examin		-		n, give street and number)			4b. City, Town, or	n	4c, County of Death MONTGOMERY			
	F		SHADY GROVE ADVENTISE 5. Social Security Number 6. Sex 7. Age			(In yrs. last birthday)		If Under 1 Year	ROCKVILLE FUnder 1 Year If Under 24 Hrs. 8		th	9. Birthplace (State or Foreign	
	Funeral Director		infant	1)	X		Yrs.	Months Days	Hours Min.	(Month, Da		m_E^{Co}	DRYLAND
Т	how at	٦٢	Usual Residence of De 10a. State 10	ob. County		10c. City, Tov	vn or Loc	ation					10d. Inside City Limits
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ecto	MD Montgomery			Rockville							1 ☐ Yes 2X No
		١	10e. Street and Number			10f. Zip Code 208.			1 *		10g. C	Citizen of What Country? USA	
		Funeral Director	13208 Twin	Brook I	2kwy #204 12. Was Decedent E	uor in II S	112 14	/as Decedent of Hi		pecify Yes or No-		14. Race - Ame	arican Indian
ပ္		by Fu	 Marital Status Never Married 	Armed Forces?	Armed Forces? 1 ☐ Yes 2 1 No		Yes, specify Cuba	n, Mexican, Puerto Rican, etc.)			Black, White, etc.		
Ö		ted I	3 Widowed 4 Divorced If Yes, Gi Year or D									Specify: hispanic	
15-(Completed	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)			ation Juring most of wo	it of working		, Kind of Business Industry	
212			Elementary/Seconday (0-12) College (1-4 or 5- infant infant			+)						infant	
Baltimore, Maryland 21215-0036		To Be	17. Father's Name (First, Middle, Last)					unk	18. Mother's Name (First, Middle, Maiden Surname) Jennifer Arana				
			I					g Address (Street a	treet and Number or Rural Route Number, City or Town, State, Zip Code)				
e, N			Shady Grov		tist Hosp			sition (Name of	Center	Date Ro	_	Location - City or	
imor			1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Frother Specify 1n State										
Balt			21. Signature of Euner	ral Service License	Age Aying	ctor		Name and Address ate Anato			Ва	ltimore	Street
		0	Raltimore MD 21201 23a. P. 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between										
	Physician/		Immediate Cau in Inin disease or condition		/3		nN	10 NITI	5				Onset and Death
	Medical Examiner		resulting in death)	ſ	Due to (or as a	consequence	e of):						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The state of the function of the	iner	Sequentially list cond if any, reading to imme cause. Enter Underlyi	ediale	b. Due to (or as a	tonSequence	onj.					5	Ü Ü
		Examiner	Cause (Disease or iinj that initiated events	C. Due to for as a	a consequence off-							1.0	
		edical E	resulting in death) Las	î L	Due to (or as a consequence of):								
3760		/edi			d								
Box 68760		an/N	IF FEMALE: 23b. Was decedent pro in the past 12 mo	egnam	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3				ру			23d. Date of delivery Month Day Year	
. Bo		ysici	1 Yes 2 1		4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ∟	Other (specify)				Month	Day Toar
P.O.		by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying co						ven in Part I.				to the cause of death?
rds		eted								24a. Was			utopsy findings available
3eco		Completed									DDSV	prior to	completion of cause of
al F		Be C	25. Was case referred examiner?	-	In the latest terms of the				ace of Death (Che				
fζ	Physic this or al dire	၉	1 ☐ Yes 2 💢 I	No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
o u	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	cate	-2	5 Pending Investigation	(Month, Day, Year) injury			work? M 1 \(\text{Yes} 2 \text{ No} \)		Zou. Describe	od. Describe now injury occurred		
Division of Vital Records,		Certificate:		6 Could not be determined					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ö		Medical (29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										tated.
		Mec	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	F 3 F ŏ		72470 1014/11										
			30. Name and adoress			eath (Item 23a	(Type, P	Print)		D) - n/	100110
JILLIAN LOPIANO MD 9901 MEDICAL CENTER DRIVE ROCKVILLE, N State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature												INKYLAND	
State 31. Date filed (Month, Day Year) Registrar 32. Hegistrar's Signature A. Asarkal													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29c per dvr / g920 10-27-11 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 1603 HARRY 20 ZE II EDEAK 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UPPER CHESAPEARE MEDICAL CANTER HARFORD AR BEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year **1**XX M 2 □ F Months 217-16-0369 88 Yrs Director Ĩ922 Marvland Nov Usual Residence of Decedent 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits must be notified at death with the Maryland Director 28a-f Maryland Harford Fallston 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21047 USA 2305 Furnace Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 XXYes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 X Widowed 4 Divorced WWll White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. I **other than** " Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other the other traumatic event, the 12 yrs. N/A Industrial Engineer Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ₽ Anne Schatz Harry Auld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is 2305 Furnace Rd. Fallston, Md. Christina L. Craig (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Department o Important: If any injury or ò 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10-21-2011 Baltimore, Md. 22. Name and Address of Facility Lassahn Funeral Home Signature of Funeral Service Licensee 7401 Belair Rd. Baltimore, Md. E. J. Lassahn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ INDIAC CANIAL HAM ORE HAYE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** UN CONTROLLAD Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Auld, Hurry #29c Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atter in the past 12 months?
1 Yes 2 No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes To the Hospital or Attending Physician: The law requirawithin 24 hours after death.

To the Funeral Director After this certificate has been significated filed in by the funeral director, page 2 should be completed filed in by the funeral director, page 2 should be. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 🗌 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Example: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Name Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 [29b. Signature and title of certifig 29c. License number 29d, Date signed (Month, Day, Year) 20/201 D-6736030. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPPER CHESAPGARE MICHAEL BOL AR 21014 ASSIAHAM MO 31. Date filed (Month isträr's Signatu State CALANT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edna 9:26 P M Barnett Ann OCTOBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH ME, DICAL CENTER JIMORE TOW SOM If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Davs Hours Min. (Month, Day, Year) 215-64-1923 56 **Director** 1 🗆 M 2 🔏 F Jan 12 1955 MD Usual Residence of Decedent rinit. Page 1 and 2 should be filed within 72 hours after death with the Maryland earthent of Health and Metal Hygiene. earthent of Health and Metal Hygiene. cortant. If them 27 is anawards of their than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carrol1 Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5532 Hodges Road 21784 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😿 No Specify: Specify: black 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) medicine aide |health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dorothy Elizabeth Moals Filmore Costley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert L. Barnett (spouse) 5532 Hodges Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State All County Cremation | 10-30-11 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) permi Depar Impor any inj 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Days Harget Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARDIOMYOPATHY disease or condition YEARS Medical resulting in death) Due to (or as a consequence of): Examiner RCOIDO YEARS Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year 1 Yes 2 No 9 Unknow signed by the a d be detached 1 Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours after death.

the Funeral Director. After this appletely filled in by the funeral of 27. Manner of Deatl Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pendina 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the To the To the Comple 29d. Date signed (Month, Day, Year) traut D36663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STUART RICHARD WI OSLER DRIVE

DHMH 17 Rev 06-2011

State Registrar

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle, Last) Physician/ omia Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Randallstown Seasons Hospice of Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 4, 1931 Birthplace (State or Foreign Country) **Funeral** Davs Hours Min. 1 🗆 M 2 💆 F NC 217-28-1127 80 **Director** 28a-f show 10d. Inside City Limits death with the Maryland notified at 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 No **Baltimore** MD **Baltimore** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r items 23a or ner must be n ö Funeral 3204 Gartside Avenue 21207 U,S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc ŏ ģ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Hygiene. life. DO NOT use retired). Elementary/Secondary (0-12) College (1-4 or 5+) Day Care Provider Private Day Care 12 event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H

27 is marked of
traumatic ever မ Rosie Smithwrick John H. Smithwrick t. Page 1 and 2 should be trent of Health and Men trant: If item 27 is marke jury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3204 Gartside Avenue Baltimore, MD 21207 **Theodore Bonds** Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Department I Important: If any injury or Oct 28, 2011 Crownsville, Md. **Crownsville Veterans Cernetery** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pliv ician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a consequence or) If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending polytope ld be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy 1 Yes certificate 2 No 1 Yes 2 N 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Certificate: To Be Other: 4 Nursing Home 5 Residence 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 Tyes M 2 🗌 No the Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled i by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗀 29b. Signature and title of 29c. License number

State Registrar 30. Name and address of person who completed

Daly, Year)

0

31. Date filed (Month

23a) (Type, Print)

cause of death (Iten

State Registrar (Check

31. Date filed (

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Stroup,

29b. Signature and title of certifier

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D65843

Old Court Road, Randallstown, MD 21133

29d. Date signed (Month, Day, Year)

october, 21, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ TM Medical 4c. County of Death Examiner N/A 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign st birthday **Funeral** 1 X M 2 🗆 F Hours 216-90-3855 51 MD Director Jul 23, 1960 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location Director or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21216 U.S.A. 2734 Harlem Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Skilled Worker Sealy Mattress** 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **Ruby Brewer** Aaron Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 in any injury or other tra **Hurdiseay Brewer** 2734 Harlem Avenue Baltimore, MD 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ₹ 1 🗴 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Lansdowne, Maryland Oct 19, 2011 Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Betwe Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Unknown 2 No the g 🗌 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform eral Director: After this certificate I filled in by the funeral director, page 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ျ 1 npatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 🔲 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\int\) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Robert Phillip Castle ,Jr. 2011 4:00 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 7819 Chesapeake Road Pasadena 5. Social Security Number 9. Birthplace (State or Foreign If Under 24 Hrs. If Under 1 Year 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours M 2 D F Md . 0876871950 Director 61 214-58-6727 28a-f shov J Hygiene. I other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Anne Arundel Pasadena Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21122 7819 Chesapeake Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Yes 2 XNo altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify:White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvent Carpenter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o permit. Page 1 and 2 should be fi Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ev once. မ Bonnie Jean Smythe Robert P. Castle, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7819 Chesapeake Road, Pasadena, Maryland 21122 Catherine Castle (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Brooklyn Park 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/27/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4107 Wilkens Avenue Hubbard Funeral Home, Inc. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician Cance disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No eral Director: After this certificate I filled in by the funeral director, page 1 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined hours after within 24 hours a To the Funeral I Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swite Madison Drive Maemella State OCT 2 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 Per AN BD G920 10/26/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 77, October 20⁴1 1:40 PM M Mary Church Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton Social Security Number 9. Birthplace (State or Foreign Connecticut If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** Month Hours Min (Month, Day, Year) 217-60-6239 **Director** 1 □ M 2 🕮 Aug 19, 1950 white 61 Usual Residence of Deceden 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location notified at Director 28a-f 1 🗆 Yes 2 😾 No MD Prince George's Clinton 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 9211 Stuart Lane 20735 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene anima1s unk unk dog trainer/handler Department of Health and Mental Hygies Important: If item 27 is marked other I any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Mary Jane Mahr Clarence Edwin Church 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C $8128\,$ Anchor Bay Drive Algonac, MI $48001\,$ Ann Lines/cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 🛣 Other (Specify) State Andronga Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ NEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, signed by the attending physician and debt detached for use as the burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð CHRONIC KIDNEY DISEASE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen SEPSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy TYPE DIABRTES performed METLITUS 1 Yes 2 No Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ပ ER/Outpatient 3 DOA 1 npatient 2 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28c. Injury at work? 1 \square Yes 28b. Time of Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

Date filed (Month, Day, Year)

26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 30, per DVR, 9920 10-26-11 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month 4145AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN NURSING CENTER N/ABALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ XF 96 Months Days Min Hours **Director** 214-22-6161 Usual Residence of Decede or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3855 GREENSPRING **ŪSA** 21209 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: BLACK Completed 3 ₩Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HEALTHCARE -0-NURSING ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ GENT TILMAN CARRIE WASHINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL CRYOR (SON) 22 ROLAND GREEN BALTIMORE, MARYLAND 21210 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burjal 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PARK 11-27-2011 BALTIMORE, MARYLAND See IQNATHAN HIBN R2. Name and Address of Facility REDD FUNERAL SERVICE D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer their which the continued to the Funeral Director. After this course the burial-tran sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live acceptance
Pregnant at time of death
Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Å Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed^a Yes 2 N 2 No 1 🗌 Yes To the Funeral Director. After this certific completed filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🛛 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and apdress of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD, 21239 5601 Loch Raven Blvd. Ste:502 RMB Saeeduddin Khan

State Registrar 31. Date filed (Month, Day, Year)

State Registrar

Certificate of Death

Reg. No.

for use as the burial-transi and Division of Vital Records, P.O. Box 68760 signed by the attending physician I be detached for use as the buria page 2 should peen has

3altimore, Maryland 21215-0036

2. Date of Death 1. Decedent's Name (First, Middle, Las **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arundel Anne Glen Burnie Health and Rehabilitation Cntr Glen Burnie Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ₹M 2 □ F 09/25/1931 England Director 218-56-1569 80 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show or items 23a or 28a-f shown in the result of at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 England 1004 Bell Ave 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status injury or other traumatic event, the Medical Examination permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, it a Medical Exerciting Once. Armed Forces? 1 ☐ Yes 2 If Yes, Give 2 🔀 No 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Keystone Electric Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva (unknown) မ Patrick Connor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen Burnie, Maryland 21060 <u>1004 Bell Ave</u> Norma L. Connor / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial: 10/24/2011 Elkridge 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 421 Crain Highway, S.E. 23a. Part 1. Enter the disease, or complications that cause the death. Shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death EREBRO ASCULAR ACCIDENT Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) I ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROLET DR DAN 9055 82. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Month Physician/ Oct Medical Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A 8. Date of Birth (Month, Day, NOV • 03 9. Birthplace (State or Foreign Funeral 1 □ M 2 □ XF Months Hours Min. Mary land Yrs Director 89 215-14-0325 Nov Usual Residence of Decedent 28a-f show 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 X Yes 2 □ No Maryland N/A Baltimore 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? tems 23a Funeral 21202 USA 802 E. Preston St. <u>Apt</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 💆 No Specify: If Yes, Give Year or Dates 3X Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Housewife 10th grade Own Home Lepartment of Health and Mental Hygie Important: If item 27 is marked other any injury or other transmission. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Julia Smith Wesley Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 st Health a Roland N. Dorsey/Son 5412 Bucknell Road Baltimore, MD 21206 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/26/2011 4 Donation 5 Other (Specify) Zion Cemetery Lansdowne, MD 4210 Belair Road Baltimore, MD 21206 21. Signature of Juneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ ocard disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 1 months?
1 Yes 2 No
9 Unknown Month Day Year ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Unnary Track Tufecti 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Menknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 00 1 🗌 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 【✔No 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work? 1 Yes 2 No iniury 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 23a) (Type, Print) Cour

Registrar

Baltimore, Maryland 21215-0036

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23a per dr.,g920,10/26/2011dhb
Reg. No.
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10 10:03PM /Medical 4b. City, Town, or Location of Death **Examiner** 4a. Facility Name (If not institution, give street and number) 4c. County of Death timor. Social Security Number Age (In yrs. last birthday I If Under Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ₹ M 2 □ F Director 70 Yrs 156-30-6872 05/09/1941 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov if than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21217 1344 Division Street U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify: þ Specify: Black 3 Widowed 4 Divorced is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) X Ray Technician U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finand Mental H Charles Davis Grace Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a:
Important: If Item 27 Is
eny injury or other trau Tracey Durant / Niece 4617 Sandwood Road, dgemere, Maryland 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/22/2011 | Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Known disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Osteomyelitis Sequentially list conditions, if any leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Die to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Diabetes Due to (or as a consequence of): Box 68760. Hypertension Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 ☐ Other (specify) ned by the Ö ☐Yes 2☐No 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manufer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a 29a. Certifier 1 💇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 34359 (0110) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bealevard, Bulfiners, Maryland 21218 3900 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 26

11-07952 Aaron Jason Devos

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		I- For State Registrar		C	ertificate	of	Death			R	Reg. No.	has 1	1	. 0,00
Physiciar	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of I									3. Time of Death			
Medical Examin	ег	Aaron Jason De				- 14	h City Town or	Lagation	of Dooth	October 2	22, 201		f Dooth	1407 hrs
_		4a. Facility Name (if not institutio Johns Hopkins Bayvie		b. City, Town, or Baltimore	Baltimore			4c. County of Death Baltimore City			City			
Funeral Director		5. Social Security Number 212–13–2686	6. Sex XX M 2 F	7. Age (In yr 35	s. Jast birthday) Yrs.	If Under 1 Year Months Day		er 24Hrs. Min.	8. Date of Bi May	,			nplace (State or nuntry) MD .
or items 23.	Director	Usual Residence of Decedent 10a. State Maryland 10b. County Baltin 10e. Street and Number 61 Yew Rd. 11. Marital Status 1 Never Married 2 X Ma 3 Widowed 4 Divi	12. Was De	ed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.						- Americ	ean Indian, Black,			
5-0036 led within 72 hours after Hygiene "matural", other than "matural", the Medical Examiner.	Completed b	15. Decedent's Education (Spec Elementary/Secondary (0-12) 12th grade	cify only highest gra	1-4 or 5+)	durin	g mo	's Usual Occupa ost of working life enter					ke Ca		eld & Son
MD 21215-0036 d 2 should be filed within 7 and Mental Hygiene. n 27 is marked other than umatic couch, the Medics	င် မြ	17. Father's Name (First, Middle, David DeVos	Last)						•	First, Middle,	Maiden	Surname)		
e, MD 21 I and 2 should I Health and Mer item 27 is mar	٩	19a. Informant's Name/Relations Lauren DeVos (1			4		Address (Stree	et and Nun	nber or Ru	ral Route Nur		ty or Towr	n, State,	Zip Code)
ITE, s 1 an f Hea If iten		20a. Method of Disposition 1X X Burial 2 Cremation 4 Donation 5 Other Sp.			b. Place of Dis	posit	tion (Name of ce er place) PO Mem .	metery,		Date 26-201	20c. L		-	Fown, State
Baltimo permit. Page Department o Important:	(1. Signature of Funeral Service					ame and Address			sahn F ltimor				6
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.			er th	e mode of dying,	such as c	ardiac or r	espiratory an	rest, sho	ck, or hea	rt	Approximate Interval Between Onset and Death
Examilier		or condition resulting in death) Sequentially list conditions,	Due to (or as	a consequenc	e of);									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as											
760, icate be executed physician and the burial - transit		events resulting in death) Last	Due to (or as	a consequenc	e of):									
O, e be ex	/Medical	UNPENDED	AMENDED											
	Physician/M	IF FEMALE: 13b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	ne 1 Live	nant at time of	2		al death 3 er (Specify)	Ectopio	c pregnanc	су		. Date of o	,	ay Year
ords, P.O. In requires that the as been signed by the should be detached.	함	Part II. Other significant condit	lons contributing t	o death but no	ot resulting in th	ne ur	nderlying cause (given in Pa	art I.					he cause of death? ably 4 Unknown
of Vital Records, P.O. og Physician: The law requires that if ther this certificate has been signed by hard director, page 2 should be detach	Completed									1 Yes		pi de		opsy findings available ompletion of cause of S
Vital I hysician: this certifi	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No		Inpatient 2	✓ ER/Outpati	ent		Other ₄	(Check on		Resider	nce 6	Other:	
- = ∴ `45 7	⊢⊦	27. Manner of Death 1 Natural 5 Pend	28a. Date		28b. Time 1324 hrs	of In	jury 28c. Inju	ry at Work Yes 2 ✔	. 9	8d. Describe ubject sho		ry occurre	ed .	
Division pital or Atteodi ours after death. eral Director: /	Certification:	3 ✓ Suicide 6 Could	a not be		t home, farm, s amily Home		t, factory, office b	ouilding, et		8f. Location (or Town, \$ 1 Yew Road				al Route Number, City
3 - 3 > 1	ल्ल		nysician: To the be miner: On the basis and manner:	of examinatio										
		29b. Signature and title of certifie					29c. Licens					oate signe ober 23,		th, Day,Year)
D) OCME		30. Name and address of person Mary G. Ripple MD.	Deputy Chief	Medical Ex	caminer 9	00	W. Baltimore	e Street,	, Baltim	ore, MD 2	1223			
Stat Registra		31. Date filed (Month, Day, Year)		egistrar's Sign	nature		1.1							
DHMH 17 Rev 1/200		441.43	VI JOH	d	ORIGII	VAL					•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 20, 2011 0325 Augustus DeGrazia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Montgomery General Hospital Olney Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Days Hours Aug 1, 1953 Maryland **Director** 213-54-5126 1**X** M 2 □ F 58 Usual Residence of Dece 28a-f show with the Maryland ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director unk) Yes 2 No (unk) MD (unk) 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral (unk) USA (unk) items 2 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian. Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ellen O'Connor Edward DeGrazia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10419 Montrose Ave. #202 Bethesda, MD 20814 Ellen O'Connor DeGrazia/mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Durial 2 Toremation 3 Removal from State Final Journey Crematory 10/26/11 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Sq 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onse and Death MyoCypyy(Du/td (or as a consequence of Physician/ disease or condition hour Medical resulting in death) (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) of or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P,O, Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed 1 🗌 Yes 2 🗖 No 1 Yes 2 filled in by the funeral director, 25. Was case referred to medical Medical Certificate: To Be examiner? 1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{No} \) Hospital 1 Mnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

To the Hospital within 24 hours a To the Funeral L

State

DHMH 17 Rev 06-2011

29a. Certifier (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

OLNE

nature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ARThur Schoengold, M.D.

October 20

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Davis 0556 Jerry October 19 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HARFORD CO UPPER CHESAPEAKE MEDICAL CENTER BEL AIR Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Hours **Funeral** Days Months 1 X M 2 □ F 69 Yrs. March 9 1942 MARYLAND 215-40-8599 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Director HARFORD CO BEL CAMP MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21017 Funeral 1213 TRILLIUM COURT Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 50/8/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: BLACK If Yes, Give Year or Dates: 59/84 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY CORRECTIONAL OFFICER 12yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CORA WILLIAMS JESSIE DAVIS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau
once. 1213 Trillium Ct., Bel Camp, Md., 21017 Cynthia W. Davis/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-24-2011 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A
321 S. PHILADELPHIA BLVD., ABERDEEN, MD 21001 21. Signature of Fund Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Immediate Physician Mycarda disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner OVONO 11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Records. þ Diabetes 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 1 ☐ Yes 2 No Division or Vital Il or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bata 103 Belcamp State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ october 20 2011 4:29 pM Alvin R. Eaton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Mar 13, 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🕅 M 2 🗆 F 1920 Ohio Director 91 <u> 286–12–4070</u> Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2x No MD Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21029 USA 6701 Surrey Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ APL-JHU Aeronautical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Katherine Hasel Alvin Ralph Eaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 Surrey Lane Clarksville, MD 21029 Ellen G. Eaton/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 10/22/11 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 MO1251 Heckrotte, P.A. Clarksville Beverly L. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROSTATE CAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts) Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Month Day ed by the a P.0. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 🗌 Yes 2 🗶 No HOSPICE ျ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the t 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

DANIELLE

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

164395

29d. Date signed (Month, Day, Year)

COLUMBIA, MD 21044

OCTOBER 21, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FIGANIAK LEWIS October Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death Regional Hospital Prince George's -aurel 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 1 **X** M 2 \square F Months Days Hours (Month, Day, Year) 09-29-1949 Director 153-40-9108 P<u>ennsylvania</u> Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Howard Laurel 10e. Street and Number ò 10f. Zip Code 10a. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 9516 Queens Guard Court 20723 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. was Decedent Ever in U.S.
Armed Forces?

1 XX yes 2 \(\times \) No
If Yes, Give Air Force
Year or Dates. Black, White, etc. þ 1 Never Married 2xxMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 4+ Logistics Manager GDI America Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter L. Figaniak Anna Hendrickson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Figaniak (Wife) 9516 Queens Guard Court Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 🛣 Cremation 3 🗆 Removal from State 10-25-2011 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes 21. Signato Licensee 5555 Twin Knolls Road Columbia, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Onset and Death Acute Infarction Myocardia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Examine Daw to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Year 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 1 Tes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 戻 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) October 24, 2011 5861 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road Regional Munim, MD Abdul -dure/ 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G921 11/01/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:35 **Physician** Mary 2011 3 Lawrence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville 717 Maiden Choice Lane #211 If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Dat) Gear) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours Months 1 ☐ M 25 F 218-36-6108 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show amy injury or other traumatic event, its Medical Ezanitral must be notified at once. 1 ☐ Yes 2 No Directo Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21228 USA 717 Maiden Choice Lane #211 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coltege (1-4or 5+) Elementary/Secondary (0-12) Medica1 Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eva May Bazzell Harvey Hershey Riddle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14075 Davana Terrace; Sherman Oaks, CA 91423 Charles Lawrence Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 10/27/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Juneral Service Licenses 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Me tastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the e page 2 should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2. No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner-of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu death. 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D4437 mus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

7-11

32 Registrar's Signature

mo

Bow lin

26

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $0CI^{Month}$ Day Physician/ 201 Tea 10:35p м William Jerome Glass, Sr. 24, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F MAY 2. 1943 Months Hours Min. Mary Land 68 Director 213-40-1816 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10a State 10c. City. Town or Location notified at Director 1 Yes 2 No 28a-f Sykesville Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be USA 21784 23a Funeral 7750 College Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) 5 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insulation Salesman 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mildred Burdette Delton Clay Glass, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7750 College Road Sykesville, MD 21784 19a. Informant's Name/Relationship (Type, Print) B. Lynne Schildt/daughter 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Department of Important: If any injury or once, 10/28/2011 Sykesville, MD Lake Viem Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) P.O. Box 195 Sykesville, Signature of Funeral Service License P.A. MO0764 MD 21784 (410-795-1400) P.0. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car is or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ led by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Yea Month Day Pregnant at time of death 9 Unknown Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed 1 Yes 2 No Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 10 မ 1 Inpatient 2 I ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: After t Natural 5 Pending s after death.

I Director: After din by the fundament 1 Yes 2 No Accident Investigation Could not be Suicide within 24 hours after de

To the Funeral Directo

completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifie 29d. Date signed (Month, eted cause of death (Item 23a) (Type, Prin Westminster, MD 21157 Stoner 292 tuenue, Havio 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland Jem 26 per verb., g920	Department of Health a • 10/26/2011 dhb Certificate of Death	and Mental Hygi	iene _{eg. No.} 2011 34089		
			Decedent's Name (First, Middle, Last)		2. Date of Deatl	h 3. Time of Death		
	Physicia Medic		Mildred F. Greco	1 0 1	2 Day 20 Year 8:52am M			
Sec. 1	Examin		4a. Facility Name (if not institution, give street and number)	of Death	4c. County of Death			
and the			6210 Latchlift Court	24 Hrs. 8. Date of Birth	Howard			
	Funeral Director		5. Social Security Number 6. Sex 7. Age $(ln\ yrs.\ last\ birt)$ 1 $(ln\ V)$	Months Days Hours	Min. (Month, Day,	Year) Country)		
100	LA LINE		Usual Residence of Decedent	Yrs.	11/19/			
	land f shor d at	to	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits		
	Mary 28a-i	Director	MD Howard Elkri			1 \(\text{Yes 2XXNo} \)		
	th the		10e. Street and Number	10f. Zip Code	1	Og. Citizen of What Country?		
	ath wi	Funeral	6210 Latchlift Court 11. Marital Status 12. Was Decedent Ever in U.S.	21075 13. Was Decedent of Hispanic Ori	ain? (Specify Yes or No-	U.S.A. 14. Race - American Indian,		
21215-0036	e filed within 72 hours after death with the Maryland that Hyglene. All Hyglene. other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	Armed Forces? 1 Never Married 2 Married 3 X Widowed 4 Divorced Armed Forces? 1 Yes, Give Year or Dates.	If Yes, specify Cuban, Mexicar 1 Yes 2 No Specify:	n, Puerto Rican, etc.)	Black, White, etc. Specify: White		
2-0	hour 'natu	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during mos	at of working	16b. Kind of Business/Industry		
2	hin 72 ne. than '	om	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use retired)		Healthcare		
2	Hygiene. Other than ent, the M	Be C	17. Father's Name (First, Middle, Last)	egistered Nurs	er's Name (First, Middle, N			
Maryland	be filed ental Hyg ked oth ic event	To E	Frank Fornataro		y Pecora	natueri Surname)		
ary	1 and 2 should be fil if Health and Mental item 27 is marked o other traumatic eve			. Mailing Address (Street and Number		City or Town, State, Zip Code)		
	d 2 st alth a 1 27 is er trai		Jean Marie Modresky 62	10 Latchlift	Ct., Elkri	dge, MD 21075		
Jre,	_ = 0		·	f Disposition (Name of ry, crematory or other place)	Date	20c. Location - City or Town, State		
<u>ii</u>	Page nent c ant: If ury or		Bullal 2 Ciellation 3 Heliovaliloni State		10/17/11	Hazleton, PA		
Baltimore,	permit. Page Department or Important: If any injury or once.		21. Signature d'une le licensee	22. Name and Address of Facili		neral Home eton, PA 18201		
	1		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart falure. List only one cause on each line.	not enter the mode of dying, such as	cardiac or respiratory arre	Interval Between		
F	Ph _{sician/}		Immediate Cause (Final disease or condition	enalic &	9	3 m		
Town or the last	Medical Examiner		resulting in death) Due to (or as a consequence	of):				
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	war -				
	ed	Examiner	iri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	01).				
	xecut n and al-tra		that initiated events c. Due to (or as a consequence	of):				
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9289	ificate k ig phys as the	Med	IF FEMALE:					
ŏ ×	eath certifica attending ph I for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal deat			23d. Date of delivery Month Day Year		
Вох	he att	/sici	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month Day Year		
P.O.	es that the deat igned by the at be detached f		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part	I. 23e. Did tob	bacco use contribute to the cause of death?		
S, T	signe d be	Completed by			1 🗆 Y	res 2 No 3 □ Probably 4 □ Unknowr		
ord	requires been signal	lete			24a. Was a	n 24b. Were autopsy findings available		
ec	e has age 2	dwo			autops perform	prior to completion of cause of death? 2 No 1 Yes 2 No		
<u>=</u>	sician: The lav certificate has lirector, page 2	Be C	25. Was case referred to medical	26. Place of Dea	ath (Check only one)	2 1 0 NO 1 TE 165 2 E NO		
<u>K</u>	ysician: iis certific director,	To B	examiner? 1 ☐ Yes 2 【▼No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 DOA Other: 4 N	lursing Home 5 X Reside	ence 6 Other (Specify)		
of	ding Ph h. After thi funeral			Time of 28c. Injury at injury work?	28d. Describe ho	ow injury occurred		
Division of Vital Records,	tendi Jeath. Ior: A the fi	Certificate:	2 Accident Investigation	M 1 ☐ Yes 2 ☐		D. I Davida Museban		
ivis	I or Attendi after death Director: A d in by the f	Cert	4 Homicide determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (St City or Town	treet and Number or Rural Route Number, n, State)		
D	Hospital 24 hours & Funeral C	cal	29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and	d place, and due to the cau	use(s) and manner as stated.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic	Medical	(Check 2 Medical Examiner: On the basis of examination and/only one) 3 Certifying Nurse Practitioner; to the best of my known	or investigation, in my opinion, death o	occurred at the time, date an	nd place, and due to the cause(s) and manner stat		
	To the within 2 To the comple	-	29b. Signature and title of Certifier	29c. License number	2	29d. Date signed (Month, Day, Year)		
)		> stepling m	0 10262	94	10/12/11		
))			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) Redent R	1 catons	10/12/11 ille MD 21338		
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	arke				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per verb., g920, 10/26/2011 dhb

Certificate of Death

Amend Item 26 per verb., g920, 10/26/2011 dhb

Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Davs Hours Min. 213-26-7774 **Director** 1 □ M 2 🛣 MD 8/2/1929 Usual Residence of Dece 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at Director MD Anne Arundel Annapolis 1 Yes 2xXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 2529 Sandy Run Court within 72 hours after death Was Deceus. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. the Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ö þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2¾X No Specify: If Yes, Give Year or Dates "natural", White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education 4 Teacher of Health and Mental Hygie If item 27 is marked other r other traumatic event, tt To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Rachel Dubois Edward Early 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2529 Sandy Run Court Annapolis, MS 21401 19a. Informant's Name/Relationship (Type, Print) Ernest Green, husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Uniformed Serv. Univ. 10/25/2011 Bethesda, MD 4 🖾 Donation 5 🗆 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Sycs. Signature of Funeral Sevice Licenses 26 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Cardial disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death been signed by the a should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 2 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Fractitioner to the best of my incomedate, seath occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Certifying Nurse Fractitioner: To the best of my knowled

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year,

448 2. Registrar's Sig Hure 29c. License number

29d. Date signed (Month. Dav. Year)

DHMH 17 Rev 7/2009

Registrar

21215-0036

Maryland

Baltimore,

Box

P.O.

Records,

Division of Vital

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Ellan Green 1743 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ST. AGNES HOSPITAL BALTIMORE 9. Birthplace (State or Foreign Country) SC 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month Day Year 1935 1 M 2 XF Months Days Hours Min 213-34-2356 76 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No **Baltimore Baltimore City** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 U.S.A. **625 West Grantley Street** Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married δ 1 ☐ Yes 2 ☐ No Specify: **Black** If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) M's Filbert Margarine Inspector 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Minnie Johnson Willie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 West Fayette Street Baltimore, MD 21223 **Dollie G. Truesdale** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oct 25, 2011 Baltimore, Maryland **Arbutus Memorial Park** 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Non-Eschemic disease or condition resulting in death) unknown Medical Due to (or as a consequence of) **Examiner** urknown MRSA bneumon Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cons - uence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ompleted by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Cardiopulmonary arrest 24a. Was an performed?

Division of Vital Records, P.O. Box 68760 this certificate has been To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page

GREEN

ַ		The res 2 to No. 1 to 1 tes 2 to No.							
מ	25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
2	1 🗆 Yes 2 🗸 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)							
licate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation								
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
3	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.							

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and				29c. License number		29d. Date signed (Month, Day, Year)		
Mee	enakshi	RESIDENT -	PHYSICIAN	P DCCI	_	10.18.2011		

P- 26615

10.18.2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEENAKSHI	DAG	HAR.	900	8.	CATON	AVE	BALTIMORE	M.D
31. Date filed (Month, Day, Year)	~~ ~~	32. Registra	ar's Signatu	ire		,		

State Registrar

6V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 22, 2011 **Physician** 3:00 PM Greene Fredric Marc /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lorien Nursing and Rehabilitation Ctr Columbia Howard 8. Date of Birth (Month, Day, Year) April 27, 1946 Birthplace (State or Foreign Çountry) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1 X M 2 □ F New 064-38-1708 York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Directo Columbia Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21044 10750 Cordage Walk Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates:64-66 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 🗓 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 in and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Contractor Roofing permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aaron Harold Greene Anna Ruth Schoenfeld ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Henley- Companion 10750 Cordage Walk, Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ី Cremation 3 ☐ Removal from State Atlantic Crematory 10-25-2011 GlenBurnie, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licenses M0123 5555 Twin Knolls Road , Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG WITH METASTATIC BRAIN LESIONS **Physician** CANCER MONTHS disease or condition resulting in death) /Medical Examiner UNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. ed by the a TYPS 2 No 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Wall Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After thi funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the funeral or the funeral o 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

OCT 26 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAQVI

MD 6334 CEDAR 32. Begistrar's Signature

ORIGINAL

LANE, COLUMBIA, 21044, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day Month 12:40A M George Henry Huber 2011 10 20 Medical a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur WICOMICO If Under 1 Year If Under 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthdav 8. Date of Birth **Funeral** 1 ₹ M 2 □ F Months Hours Min. (Month, Da 120-14-7102 86 New York Director Jan Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits Director 1 ☐ Yes 2X No MD Crisfield Somerset 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 21817 5060 Manokin Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 X Married ☐ Yes 2 🗓 No þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: white Specify: Completed 3 Widowed 4 Divorced er than "natur , the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Seconday (0-12) College (1-4 or 5+) construction plumber 12 item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Page 1 and 2 should be Elsie Wilhemina Taylor George Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trat 5060 Manokin Road Crisfield, MD 21817 Madeline Huber/spouse CHONGE, I 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) ^{22 Name and Address of Facility} State Anatomy Board 655 W. Baltimore Street Raltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or beart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death MALIGNAN LYMPHOWA Ph si i n disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of if any leasing to himedicause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 🗌 Yes 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No completed filled in by the Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Lertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

acke

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ueron

26

31. Date filed (Month, Day, Year)

00058410

10-20- 2011

11-07529

Richard Heckel		State of M	aryland / Departme				ble.	
		1- For State Registrar		ate of Death	and montain	Reg.	No. 201	1 31.00
Physici Medical Exami		Decedent's Name (First, Middle,Last) Decedent's Name (First, Middle,Last)	 			2. Date of Death		3. Time of Death
iculcai Exami	1161	Richard Heckel 4a. Facility Name (if not institution, give street Johns Hopkins Bayview	and number)	4b. City, Town	, or Location of Deat	Month Cottober 7, 2	4c. County of Death	1943 hrs
Funeral Director		5. Social Security Number 6. Sex 213-36-3269 1 M 2	7. Age (In yrs. last birth		Year If Under 24Hr Days Hours Mir		(MM/DD/YYYY) 9. Birt 1939 Foreig Cou	hplace (State or n untry)Maryland
with the Maryland ns 23s nr 28s-f show any te notified at nace.	ral Director		Road as Decedent Ever in U.S.	ltimore 10f. Zip Cod	21224		. Citizen of What Cour USA 14. Race - Americ	
MOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a nr 28a-f shor or nother traumatic event, the Medical Examiner must be notified at nace	leted by Funeral	3 Widowed 4 Divorced If Yes, C or Date 15. Decedent's Education (Specify only higher	Sive Year s: est grade completed) 16a. D	If Yes, specify Cu 1 Yes 2 X Decedent's Usual Occuluring most of working	upation (Give kind of	work done 1	Specify: white 6b. Kind of Business/li	:e
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Comple	unk unk 17. Father's Name (First, Middle, Last)		labo unk	18.Mother's Name	First, Middle, Ma	,	
21; thould be nd Men	인	19a. Informant's Name/Relationship (Type, Prin	nt) 19b.	Mailing Address (S	treet and Number or	Venubrey Rural Route Numbe	er, City or Town, State,	Zip Code)
Baltimore, MD 21215-00; pernit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or ruther traumatic event, the Med		Sharon Dobbs/frience 20a Method of Disposition 1 Burial 2 Cremation 3 Rem	20b. Place of cremato	624 Sandy Disposition (Name of ry or other place)	Plains Ro	ad Dundal Date	k MD 2122 20c. Location - City or	7.2 Town, State
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite injury or other tr		21. S ature of une ervice License Ronal d S	State Strector	Raltimore	MD 212	Ω1	Baltimore	Street
Physician /Medical xaminer			that caused the death. Do not Clications of or as a consequence of):	enter the mode of dyi	ng, such as cardiac o	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
sd sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	or as a consequence of):					
executed an and al - transi		d d	DED 23a,pt.II,2	7.28a-f.pe	er me.g923	1-18-12	SM	
Records, P.O. Box 68760, The law requires that the death certificate be are has been signed by the attending physicione 2 should be detached for use as the burning 2	hysician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9	f yes, outcome of pregnancy Live birth 2 Pregnant at time of death 5 Unknown	Fetal death Other (Specify)	3 Ectopic pregna		23d. Date of delivery	ay Year
ires that the signed by	全	Part II. Other significant conditions contributions Chronic Obstructive					cco use contribute to t	
of Vital Records, as Physician: The law require this certificate has been sineral director, page 2 should be	Completed	Fibrillation; Hypert	-	cusc (dolb)	, Atliai	24a. Was an autopsy	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
Vital Revysician: The his certificate director, page	B B	25. Was case referred to medical examiner?		26.Pla	ace of Death (Check		No 1 Yes	2 No
Physic Physic er this	위	1 ✓ Yes 2 No	Total Parisin 2 Electronic	patient 3 DOA		g Home 5 Re		
- # ^4	Certification:	1 Natural 5 Pending 2 Accident Investigation for	(Month, Day, Year)	nown 1	njury at Work? Yes 2 K No e building, etc.	28d. Describe how unknown 28f. Location (Stre		al Route Number, City
Hospi 24 hour Funer tely fil		4 Homicide determined (Sp. 29a. Certifier (Check only 1 Certifying Physician: To ti	recify) Found: Nurs	h occurred at the time	, date and place, and	or Town, State Baltimore due to the cause(s	e)1046 North e, Md.	Point Blvd
To the within To the comple	Medical	2 Medical Examiner: On the land man 29b. Signature and title of certifier	basis of examination and/or inv nner stated					
		30. Name and address of person who complete	d cause of death (How 22a)		ense number C.M.E.		9d. Date signed (Mon October 8, 2011	tn, <i>D</i> ay, Year)
		Laron Locke MD. Assistant Me	,	N. Baltimore Str	eet, Baltimore, I	MD 21223		
Sta Registi	te ar	31. Date filed (Novity, 124, 6ea 2011	32. Registrar's Signature	rekal		-		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Juanita Shirkley Henderson 6:16 P M October 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15320 Durant Street Montgomery Silver Spring . Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Hours **Director** 1 □ M 2 💢 F 224-07-0890 oct 30, 93 1917 Virginia Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location be notified at Director 10d. Inside City Limits 1 ☐ Yes 2X No MD Montgomery Silver Spring ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 15320 Durant Street 20905 USA items ; Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4X Divorced er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Salesperson Retail event, th 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of ir traumatic ever မ Raymond Shirkley Elizabeth Sabiston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Carole DiBiase/daughter 15320 Durant St. Silver Spring, MD 20905 Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 10/26/11 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD Signature of Funeral Service 22. Name and Address of Facility Coing Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Debility disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to lor as a nonsequience of Exami burial-transi Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Yes 2 X No be detached Unknown 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiac Arrhythmia Division of Vital Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypothyroidism 24a. Was an has page 2 autopsy performed? 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No 1 ☐ Yes 2x☐ No or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 X Yes Hospital 2 🗆 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5X Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely (Check within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month. Day, Year) own D25344 Oct 24, 2011

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of per-

J.

Robert

who completed cause of

M.D.

32. Registrar's Signature

Ginsberg,

3905 National Drive #220 Burtonsville, MD 20866

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Hollinger October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 27 Cartwright Court Baltimore Rosedale If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F (Month, Day, Yea 6/9/1939 Country) Maryland Director 216-36-9858 Usual Residence of Decedent 27 is man ed other than "natural", or items 23a or 28a-f show traumati: event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No <u>Maryland</u> Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 27 Cartwright Court 21237 S. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify: Completed White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Office Manager Property Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Lomonico Marie Raspe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Marie Jordan (Daughter) 14 Villa Capri Circle Essex, Maryland 21221 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) Faith Mem. Overlea, Maryland ature of Furieral Service Licens 21. Sig 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue Maryland 21221 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest eart failure. List only one cause on each line. Approximate ck, or Interval Between Non-Small Cell Immediate Conse (Final Physician/ Metastati disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of and I-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Mcnth, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending Natural Accider Suicide 5 Pending injury thin 24 hours after death. the Funeral Director: After mpleted filled in by the fun Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Ched Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only d 29b. Signat e and title of certifier 29d. Date signed (Month, Day, Year) 045390 October 25th 2011 Se of death (Items 3a) (Type, Print) Philadelphia Road #208, Baltimore, InD21237 10 V

DHMH 17 Rev 7/2009

Registrar

Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 34098 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HARVEY LORRAINE В. October 2011 12:00₺ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CO LORIEN-MAYS CHAPEL TIMONIUM Social Security Number 8. Date of Birth (Month, Day, Yo NOV . 19, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Year) 19<u>28</u> 1 M 2 XF Days Hours Country) MARYLAND **Director** 82 Yrs. 220-22-0043 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No MARYLAND HARFORD CO CHURCHVILLE ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 2915 LEVEL RD. 21028 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: BLACK Year or Dates event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ishould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 7th grade CUSTODIAN BALTO CO BOARD OF ED. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. FRANK GREGG SIDNEY GREGG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George F. Harvey/Husband 2915 Level Rd., Churchville, Md., 21028 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) HOLLY HILLS MEMORIAL 10-29-2011 MIDDLE RIVER, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME THARFORD, P.A.
321 S PHILA. BLVD., ABERDEEN, MD 21001 21. Signature of uneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death END Physician/ SMEE RENAZ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DYSPHTELA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown FAILURE CONGESTIVE HEARS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2. No 1 🔲 Yes Be 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 2 D No 2 Accident
3 Suicide
4 Homicide 1 Tyes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or

Registrar DHMH 17 Rev 7/2009

State

29b. Signa

6 FO

re and title of dedifie

who co

6

30. Name and addless of person

31. Date filed (Month, Day, Year)

CRNP

CHARLES

mpleted cause of death (Item 23a) (Type, Print)

57

STE

29c. License number

4105

RO79544

TOWSON MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NMAN Month 1.50 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b City, Town, or Location of Death 8. Date of Birth (Month, Day, Ye If Under 24 Hrs. 7. Age (In vis. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Hours Min Months NORTH 218-28-Director CAROLINA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" -- " any injury or other traumatic event "..." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No MARYLAND N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 LUCIA AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK 3XXWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LUTHERAN HOSPITAL llth grade NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ LEVY TAYLOR JULIE ANN McARTHUR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roseita Inman/Daughter 507 Lucia Ave. Baltimore. Marvland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) DRUID RIDGE CEMETERY 10-27-11 BALTIMORE, MARYLAND Name and Address of Eacility
LLIAM C BROWN COMM
06 W NORTH AVENUE, COMMUNITY FUNERAL HOME P.A. ENUE, BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final SPIRATION Physician/ NEUMDNIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier D 22598 m

Registrar

DHMH 17 Rev 7/2009

State

mi

2835

SMITH AVE,

BALTO MI) 2/201

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASNEEM

31. Date filed (Month, Day, Year)

OCT 2 6 2

Ryan Wesley Jackson 11-07734 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day October 15, 2011 Medical Examine 1420 hrs Wesley Jackson Ryan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5500 blk Pennington Avenue **Baltimore** N/A 5. Social Security Number If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 24Hrs. **Funeral** Months Davs Hours Min Director 2 F Country) MD 217-37-7629 1X XM 12/14/1992 18 Usual Residence of Decedent iny 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien. Department of Health and Mental Hygien. Importantly, or items 23s nr 28s-f shu Important. If item 27 is marked uther than "natural", or items 23s nr 28s-f shu injury nr nther trammatic event, the Medical Examiner must be notified at once. MD rector N/ABaltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ۵ 3607 West Bay Avenue 21225USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? White etc. Yes 2X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Unemployed Unemployed 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First_Middle_Maiden Surname) Be Reginald Jackson

19a. Informant's Name/Relationship (Type, Print) Reginald Hunt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1867 Engle Street, Reginald Jackson Sever, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 N Burial 2 Cremation 3 Removal from State 10/22/11 Glen Burnie, Md. Glen Haven Cem 4 Donation 5 Other Specify: 21. Sign e of Funeral Service Licons Alame and Address of Facility Estep Brothers Funeral Service, PA 1300 Eutaw Place, Baltimore, Md. Part I. Enter the disease, or complications that Physician aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line, Between Onset and /Medical Death a. Multiple Chopping Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - transi Physician/Medical UNPENDED AMENDED To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the this certificate has been signed by the attending idrector, page 2 should be detached for use as t 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>á</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 2 1 Yes funeral 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Subject assaulted FOUND: 1 Natural Pending 1 Yes 2 ✔ No Tn the Funeral Directur: completely filled in by the Oct 15, 2011 1403 hrs 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 5500 blk Pennington Avenue, Baltimore, MD determined (Specify) Woods 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated g 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

11

Zabiullah Ali, M.D. Assis

State
31: Date filed (Month; Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

DOME

October 16, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 45 tate of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician llie 10 20 2011 6:11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign **Funeral** 1□ M 2▼F Months Days Hours Min 212-34-9290 Director ろり Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov Director altimore 1 Tes 2 No Γ 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygii Important: If Item 27 is marked other any Injury or other traumatic event, If once. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma Be Pages 1 and 2 should be 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockhill, S.C. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode ordying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): CHOLECYSTITIS, CHOLANGITIS, PNEUMONIA Examiner Se uentially list and large if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine GALL BLADDER CANCER WITH METASTASIS burial-tra Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy in the past 12 Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RHEUM ATOID ARTHRITIS, DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPOTHYROIDISM, GOUT, HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 2 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗆 No hin 24 hours after deat the Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 0 the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) harma ABHISHEK SHARMAMI RES 10-20-2011 Name and address of person who completed cause of death (Item 23a) (Type, Print)
BHISHEK SHARMA, MD 5601 LOCH RAVEN BLVD, GOOD SAM ARIJAN HOS PITAL, BALTIMO
- RE, MD ABHISHER SHARMA, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 6 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Franklin L. Johnson Medical 201 5:07 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday Hours Country) Director 579-96-7558 1 🛛 M 2 🗆 F 46 Dec 17, 1964 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Montgomery 1 Yes 2 No Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2601 Bel Pre Road 20906 USA unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces¹ 1 Never Married 2 Married Black, White, etc. Completed by unk Yes Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Divorced Specify. black. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education unk 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Montgomery General Hospital 18110 Prince Philip Drive Olney, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in ²² Name and Address of Facility. State Anatomy Board 655 W. Baltimore Street Baltimore, MD Part 1. Sinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosc Immediate Cause (Final Ph_sician/ ardiovascular disease or condition years Medical resulting in death) **Examiner** perten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Mar Due to (r as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy5 Other (specify) ____ Month Pregnant at time of death Day Year 2 No After this certificate has been signed by the functional director, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ Other: 1 Inpatient 2 KER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie

State

Registrar

Prince

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101

Nicho

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31. Date filed (Month, Day, Year)

Montgomery seneral

State of Maryland / Department of Health and Mental Hygiene 2011 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ackson 8:35 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel mandrin Harwood . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Days Min. Country) Scotland 1 M 2 X F 219-48-4447 88 07/14/1923 **Director** Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Pasadena 1 ☐ Yes 2 X No 9 10e. Street and Number 10g. Citizen of What Country? Funeral 302 East Pasadena Rd. items 23a Page 1 and 2 should be filed within 72 hours after death [,] ment of Health and Mental Hygiene. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XX No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 'natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2X If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed 3 Widowed 4 N Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the Me than Elementary/Seconday (0-12) College (1-4 or 5+) Yacht Sales Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Vinestock Dora Kerner 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Harry Jackson / Son 302 East Pasadena Rd., Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 10/26/2011 FT. Lauderdale ,FL EVERGREEN CENCTERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Edneral Service Licensee 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 M01452 Mary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death senter Ph_sician/ disease or condition Medical resulting in death) Examiner 1 c-Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or de a consequence of): certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE signed by the attendir 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 Ø Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Conjestive 1 ☐ Yes 2 🛱 o 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 **X**No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **X**No Other: မ ER/Outpatient 3 DOA hosper 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 ther (Specify 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1🖐 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month 1-6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Defense Huy, ANNAPOLIS, MO Marion 21401 apport MD 445 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20bac Per FH G920 10/26/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year JONES EE 1240 PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death CEVI BAUIMORE UNIVERSIT OF MARYLAND MEDICAL 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) If Under 24 Hrs 8 Date of Birth Month Day Year 1946 1 X M 2 🗆 F Days Min Director 219-50-3012 65 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director **Baltimore** MD **Baltimore City** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 3120 Sequoia Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 9/12/1964 If Yes, Give 9/11/1970 11. Marital Status 14. Race - American Indian, ò 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black 9/11/1970 Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Retail Sales Allan Stuart Company** 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ William Brooks Edna Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3120 Sequoia Avenue Baltimore, MD 21215 Christine Jones 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Garrison Forest Veterans
Druid Ridge Oct 26, 2011 10/22/2011 Owings Mills, Md. 4 Donation 5 Other (Specify) <u>Pikesville. MD</u> Signatur of Fineral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) AUTEREMI Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying AUTO IMMUNE Cause (Disease or linjury HEPATIH attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Beau Co.

Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? å Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 X No 1 🗌 Yes To the Hospital or Attending Physician: rpleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation М 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) th AU4176435H19753 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) HA 37 31. Date filed (Mo. State 2 egistrar's Signatur 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 28f per me 9921 11-4-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar amend #8 Per FH G921 11/09/2011 amend Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 15 16: HADDIE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A CENTER TIMORE RAUMA If Under 24 Hrs. 8. Date of Birth 19: (Month, Day, Year) Sep 29, 1925 1935 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under **Funeral** 1 X M 2 🗆 F 248-50-2102 86 Yrs SC **Director** Usual Residence of Deceden 10a. State 10b County aţ 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 □ No 28a-f MD **Baltimore City Baltimore** 10e. Street and Number ms 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 3786 Columbus Drive 21215 U.S.A. items be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ò þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. **Black** "natural", Completed 3 Widowed 4 Divorced Specify the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **Skilled Laborer Bethlehem Steel** 12 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie Jones Mary L. Jones permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Queen Jones 3786 Columbus Drive Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 27, 2011 Pikesville, MD **Druid Ridge Cemetery** 4 Donation 5 Other (Specify) 21. Sign, tur, of uneral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that o shock, or heart failure. List only one cause on ea Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ lui disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, rrany, leading to immediate cause. Enter Underlying Due to for as a consequence on Examir -transit Cause (Disease or iinjury that initiated events CERTIFICATION RPPROVED BY MED and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months? Pregnant at time of death Yes 2 No detached the 9 Unknown Unknown P.O. s been signed by t should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an Jas page 2 prior to completion of cause of death? autopsy performed? Yes 2 No DIABETES this certificate 1 Yes 2 No Division of Vital was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes 2 No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ieral Director; After filled in by the funer Natural Accident 5 Pending injury work? 1 🔲 Yes within 24 hours after death. To the Funeral Director; A 600 2 XNo Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 50, @ Rt, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 309 STREET Easton, Md. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie соmpleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and time of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person THOC 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month Physician/ 138 AM Actobe 2011 Medical PATRICIA DONZELLE JOYNER 4c. County of Death 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmore N/A8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Sex **)** 1 □ M 2**X**XF **Funeral** MARYLAND Director 216-56-0383 60 Ĩ1951 Usual Residence of Decedent show 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director ral", or items 23a or 28a-f sl Examiner must be notified 1 XXes 2 No BALTIMORE MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21239 1322 SHERWOOD AVENUE 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 1 Never Married 2 Married Completed by 2 X No 21215-0036 1 ☐ Yes 🗷 No Specify: Specify: BLACK "natural", 3XXWidowed 4 ☐ Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) CORRECTION INVESTIGATOR 12yrs 4yrs 27 is marked other Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ NEVA WRIGHT MORRIS T. HUTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherwood AVe., Baltimore, Md., 21239 permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tronce. Kizza Joyner/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-29-11 METRO CREMATORY BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVE., BALTO., M D 21217 21. Signature of Fund Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. 0 Onset and Death Immediate Cause (Final disease or condition resulting in death) days Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Dependent Drabetes page 2 autopsy this certificate has performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After work?
1 ☐ Yes 2 ☐ No 1 Matural 5 Pending 2 Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 To the I within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8009 October 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

OCT 2 6 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Patricia

attent known

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ OCTOBER 2011 4:40 MIRIAM KIND Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7 Age (In vrs. last birthday) **Funeral** Hours Min Director 216-14-7176 1 □ M 2 🛣 F 90 09/07/1921 MD Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Funeral Director notified 28a-f 1 Tes 2 1 No MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ь ms 23a or must be r 818 STURGIS PLACE 21208 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: "natural", 3 X Widowed 4 Divorced WHITE Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) r than the M life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SECRETARY OFFICE SUPPLIES other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I မ LOUIS SHAPIRO CRAVEN FANNIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 or other tra of Health 11300 MARBROOK ROAD, OWINGS MILLS, MD RICHARD KIND/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Department of Important: If any injury or once. BALTIMORE HEBREW CEM 10/25/2011 REISTERSTOWN, MD 4 Donation 5 Other (Specify, Signature of Funeral Service L 22. Name and Address of Facility SOL LEVINSON & BROS., 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Sose and Death hat caused the death. Do not enter the prode of dying, such as cardiac or respiratory arrest taillise Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or injury that initiated events and the burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death be detached Unknown g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2000 has page 2 certificate I or Attending Physician: 'after death.
Director: After this certifice 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Certificate: To Be Other: 4th Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No the Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide the Hospital within 24 hours Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year,

26

2011

e and address of person who completed cause of death (Item 23a) Type, Print)

HATLEW W. WELLETTIMD 2531 SHITH

32. Registrans Signature

0004337

AVE

SUITE 203

29d. Date signed (Month, Day, Year)

20/1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deat Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore n/a Secours Hospital If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours 8 7 18 7 1 9 4 8 63 Maryland 218-48-0675 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at 10a. State Director n/a Baltimore 1 X Yes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral items 23a 21223 USA 1925 Ramsey Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pizza Mfg. 12 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H 7 is marked ot မ Lloyd L. Lambie, Sr. Theoda Hissey other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or any 1925 Ramsey St., Baltimore, Maryland 21223 Neva Lambie / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State onation 5 Other (Specify) Loudon Park Cemetery 10/25/2011 Baltimore, Maryland e of Funeral Service Lic 22. Name and Address of Facility Hubbard Funeral Home, Inc. Baltimore, Maryland 21229 <u>4107 Wilkens Avenue</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last g physician and as the burial-trans burial-tran Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death ned by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 200 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has all certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to me al director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🔲 Yes 2 \ N ဂ္ 1 Parient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗆 No Accident Investigation 6
Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United States of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 22a) (Type, Print) BACTIMORO

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For	-	epartment of Health and		0 0 1 1	01.100
T = State Registrar		Certificate of Death		. No. 2	34109
1. Decedent's Name (First, Middle, Last) Physician/			2. Date of Death Month	Day Year	3. Time of Death 9:14 A M
Medical Robert J.	McDermott	4b. City, Town, or Location of De	October	4c. County of Death	J.14 A
44. Facility Name (if not institution, give si	·	01ney	ALT I	Montgomery	7
Funeral 5. Social Security Number 6. Sex		ay) If Under 1 Year If Under 24 H		9. Birthp	lace (State or Foreign
Director 115-24-8508 1 🛭]M 2 □ F 81 Yr	, , ,	, , , , , , , , , , , , , , , , , , , ,		
Usual Residence of Decedent 10a. State 10b. County	10c, City, Town o	r Location	July 8,		Od. Inside City Limits
10a. State 10b. County Was to be provided by the provided by					1X Yes 2 ☐ No
WD Montgomes	.y Bliver	10f. Zip Code	10g	. Citizen of What Coun	try?
The search with the search win the search with the search with the search with the search with	Drive	20906		nited State	es
11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e	
o b to till	1 ☐ Yes 2 ☒ No If Yes, Give	1 ☐ Yes 2 🕅 No Specify:			ite
15. Decedent's Edu	Year or Dates. cation 16a. D	ecedent's Usual Occupation	16	b. Kind of Business/Ind	lustry
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John McDermott John McDermott 19a. Informant's Name/Relationship (Typ)	B. III		aret Bunny		- (-)
		Mailing Address (Street and Number or 50 1B Gleneagles I			
Lauretta McDermot	20b. Place of D	isposition (Name of		c. Location - City or To	
O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	lellioval lioni State	crematory or other place) 1es Cemetery 10/	27/11 F	armingdale	. NY
Date 1 and 2		22. Name and Address of Facility Thomas F. Dalton	-		
Terrier 13	Mun	29 Atlantic Ave.	, Florial P	ark, NY 11	001
23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one	cause on each line.	-			Approximate Interval Between Onset and Death
Physician/ Medical Immediate Cause (Final disease or condition resulting in death)	ATheroscleratic (ordiovoscular Dise	osp.		Oliset and Death
Examiner	Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
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by the de	9 🗌 Unknown				
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The law requires are has been signage 2 should the completed			24a. Was an autopsy	prior to cor	osy findings available mpletion of cause of
Con Cotte I The Cotte			performe 1 \sum Yes 2	No 1 Yes	2 🗆 No
25. Was case referred to medical examiner? 1 Yes 2 Z No	ospital:	26. Place of Death (C			
The triple of triple o	1 Inpatient 2 ER/Outp 28a. Date of injury 28b. Tim	atient 3 LDOA 4 Nursin ne of 28c. Injury at	g Home 5 Residence 28d. Describe how		-
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27. Manner of Death a guer death b a guer death c guer	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
urs af ur					
♀ ♀ ⋾ Ѣ	er: On the basis of examination and/or it	ath occurred at the time, date and place nvestigation, in my opinion, death occurred adge, death occurred at the time, date an	ed at the time, date and p	place, and due to the cal	use(s) and manner stated.
e de	Practitioner: To the best of my knowle	29c. License number		. Date signed (Month, I	
► Mary h Mallen	_ 1/-0	H0061316	0	Joher 21.	2011
30. Name and address of person who co		pe, Print)	-2		
Michael B Williams 1) 0.	8101 Prince Phillip	Drue Olney MD 2083	32		
Registrar OCT 2 6 2011	32. Registrar's Signature	yes .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GREEN 201 55 Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death BALTIMORE N/A HOLAND **Funeral** If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Hours Min. Director 72 231-50-3731 1939_{Virg}inia Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fyaminas must be activated. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits N/A Maryland Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21215 USA 4640 Pall Mall Road 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2x No Specify: 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry ement Mason 9th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dready Mason Dora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 4640 Pall Mall Road Baltimore, MD 21215 Notis Mason/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Q/29/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Park Cemeter Loudon 21. Signa are of Juneral Servic Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home aux Reisterstown Rd Baltimore, MD21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death 18hi disease or condition resulting in death) OHERAI Medical Due to (or s a consequence of): Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence on). burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has autopsy performed 2 🗌 No 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28b. Time of After 28d. Describe how injury occurred 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 24 hours after deatl Funeral Director: Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number of death (Item 23a) (Type, Print) 8813 WAILHAM Woods Rd # 1101 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death Date of Death 2:3 Morrison Physician/ e Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Examiner** Sattimore 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Unde Country) Min. **Funeral** Hours 199-40-0722 PA Director 1 XXM 2 🗆 F 57 June 2, 1954 10d. Inside City Limits f show 10c. City, Town or Location 10b. County 10a. State death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director XX Yes 2 No Columbia Lancaster 28a-f PA 109. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 23a 17512 547 Walnut St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 XXNo permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinane. 1 Yes If Yes, Give þ 1 Never Married 2XX Married White Baltimore, Maryland 21215-0036 Specify 1 Yes 2xx No 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Church **Pastor** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Esther J. Gebhart Clifford R. Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 547 Walnut St., Columbia, PA 17512 Beverly A. Morrison Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 24, 2011 Baltimore, MD Bayview Crematory 22. Name and Address of Facility Fink Funeral Home, P.A. Signature of Funeral Service Licensee 426 Crain Hwy S., Glen Burnie, MD 21061 K Gregory Fink M01148 426 Crain Hwy S., Glen Burnie,
Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a conseq or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Year Month in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 Unknown be detached 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part ò 3 Probably 4 Unknown 2 X No 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page 2 s has perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Inpatient 2 ER/Outpatient 3 DOA 1 Yes ည this 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Date of injury Certificate: (Month, Day, Vear injury work? 1 ☐ Yes 2 ☐ No 5 Pending Natural within 24 hours after death. To the Funeral Director; A Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be filled in by Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check 3 🗆 only one) 29b. Signature and title of certifier lack MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore Naik OI Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2011 10:30 PM October Milton R. Mrowczynski Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Cromwell Center Baltimore 8. Date of Birth (Month, Day, Year If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1**X** M 2 □ F Director 9 1931 Maryland 80 Apr 217-24-0095 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is market other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 1 X Yes 2 No Wicomico Salisbury MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral USA 1109 S. Schumaker Drive #105 21804 er than "natural", or items the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force 1 X Never Married 2 Married ð Maryland 21215-0036 If Yes, Give Year or Dates. 1952. 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Company ec other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary Olszewska Peter Mrowzynski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3840 Lorcom Lane Arlington, VA 22207 19a. Informant's Name/Relationship (Type, Print) John F. Belz/POA/Executor other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ott once. 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 10/26/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Soing Home Cremation Service P.O. Box 784

Beverly I. Heckrotte, P.A. Clarksville, MD

Approx shock, or heart failure. List only one cause on each line.

Immediate Cause (Final MD 21029 Approximate Interval Between Immediate Cause (Final Americle Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Securationly list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Linksown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 1 Yes 2 No Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 2 110 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No . Manner of Death 28b. Time of Natural Certificate: 28d. Describe how injury occurred iniury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 69540. 25 11 M.D 2123 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DKI 8813 Wallham words Rd Su 204 JIgar Shah 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month C 1730 PM Rub Year 2011 Maker Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth **Funeral** 1 M 2 X F Days Hours Min. (Month Day Year) 28 Director 220-22-1254 83 Usual Residence of Decedent 28a-f shov with the Maryland 10a. State 10d. Inside City Limits Ħ 10c. City, Town or Location Director must be notified **Baltimore Baltimore City** MD 1 Yes 2 No 10e, Street and Number ò 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. or items 23a 21223 118 North Schroeder St. should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian other traumatic event, the Medical Examiner Black, White, e þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry if. Page 1 and 2 should be medicarried to Health and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired)

Homemaker (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Own Home** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Handy မ Thomas Sye 19a. Informant's Name/Relationship (Type, Print) o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

118 North Schroeder Street Baltimore, MD 21223 Mildred L. Newman 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ot netery, crematory or other place) **Arbutus Memorial Park** Baltimore, Maryland Oct 18, 2011 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) HY POKIO Medical Due to (or as a consequence of): **Examiner** Coronary DISPUSE Antery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No by the a g Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed I 1 Yes 2 No 3 Probably 4 Unknown s been significant 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificate has ral director, page 2 performed? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work?
1 Yes 2 No M s after death I Director: A id in by the f Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check rtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) DAID NOT IT 29b. Signature and t 29c. License number H67370 PHYSICIAN 2011 30. Name and add rson who completed cause of death (Item 23a) (Type, Print)

State Registrar SENTAMIN 31. Date filed (Month, Day

DHMH 17 Rev 7/2009

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BALTIMORE MP 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per verb., g920 10/26/2011dhb,
Reg. No.
Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death August 26, Physician/ 2011 5:43 PM M John Milford Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 3120 St. Paul Street #H217 Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Dav. Year) Davs Hours Director 216-44-0317 1 🕅 M 2 🗆 F 67 Yrs Nov 4, 1943 Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location ms 23a or 28a-f shormust be notified at 10a. State 10h County Director Yes 2 No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 3120 St. Paul Street #H217 21218 IISA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 1 and 2 should be filed within 72 hours after deat of Health and Mental Hygiene. Item 27 is marked other than "natural", or item there traumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 No Black, White, etc. by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced Completed unk 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk writer unk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Sarah Kitzes Kenneth C. Milford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21042 4240 Blue Barron Ride Ellicott City, MD Diana Ulman/sister 20a, Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Stated Attatomy board 655 W. Baltimore Street Signature of Sineral Service I censee Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock Immediate Case (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, Examine if an leadin to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence -transit and that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Pregnant at time of death Unknown the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hronic Undifferentiated Schizophrenia 1 Yes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 2 No or Attending Physician: after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 To the F only one) 29c. License number 29d, Date signed (Month, Day, Year) D005 7006 ame and address of person who completed cause of death (Item 23a) (Type, Print) 2524 MD 21218 Lelin Chao, MD KILK AVE ltimove 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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Kotrell Omar Newsome

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kotreli Omar N	ews	1- For State Registrar	of Maryland /		artment of <i>rtificate of</i>		nd Menta	l Hygiene	Reg. No.	20	1	1 31.	
Physic Medical Exam		Decedent's Name (First, Middle,Last NAME AND	,				-	2. Date of D Month	eath Day	Year	T	3. Time of Dea	
modiodi Exam		KOTRELL OMAR NE 4a. Facility Name (if not institution, give				b. City, Town, o	or Location of D		20, 2011 4c. C	ounty of E	eath	1545 hrs	
		48055 Spinnaker Circle #		_		Lexington				Mary's			
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Baltimore, MD 2121 permit. Pages 1 and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other trammatic event,		1 Buriel 2 Cremation 3						.0-28-201		•	•	, ,	
altin mit. P partme uportar		Donation 5 Other Specify: 21. Signature of Funeral Service Leen	seeJONATHAN	D. H	IBN P2. Na	ame and Addres	s of Facility (GILLIAM I	UNERA	LFORI	1, N 1E	U .	
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Physician Madical	2	23a. Fart I. Enter the disease, or comp failure. List only one cause on ea	ch line.				, such as cardia	ac or respiratory a	rrest, shock,	or heart		Approximate I. Between Ons	et and
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	F	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uonoo of	۸.						_		
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3760, ficate be g physici s the buri	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregn						ate of deli	-		
Box 6876 death certificat he attending phy	icia	past 12 months?	4 Pregnant at tin	ne of dea	ath ~ =	I death 3 er (Specify)	Ectopic pre	gnancy	Mor	nth	Day	y Yea	ar
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– ∄ . ੧ਫ਼	Certification:	1 Natural 5 Pending	Oct 20, 2011)	1544 hrs		res 2 🗸 No	Subject sho					- 1
Division pital or Attendi ours after death, reral Director: /	tifica	2 Accident Investigatio 3 Suicide 6 Could not b	28e Place of Injur	y - At hor	me, farm, street,	factory, office b	uilding, etc.	28f. Location or Town,		lumber or	Rural	Route Number	r, City
E G D		4 Homicide determined	(Specify) Town					48055 Spinn	aker Circle			on Park, MD	
To the How within 24 h To the Fur completely	Medical	one) 2 ✓ Medical Examiner:	n: To the best of my k On the basis of examin	nowledge ation and	e, death occurre d/or investigatio	d at the time, da n, in my opinion	ite and place, a , death occurre	and due to the cau d at the time, date	se(s) and ma and place, a	inner as s and due to	tated. the c	ause(s)	
To vit	We	29b. Signature and title of certifier	and manner stated.			29c. Licens	e number		29d. Date	signed (f	Month,	Day, Year)	-
Har.		aust				O.C.I	M.E.		October 21, 2011				
, 0,	ſ	30. Name and address of person who co Ana Rubio MD. Assistan	ompleted cause of deat t Medical Examin	•		ore Street	Baltimore !	MD 21223					
St	ate	31. Date filed (Month, Day Year)	32. Registrar's	Signatur	-	el de							
Regist	rar	OCT 26 20	Coneura	1 6	the state of the								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11 MKS 2:10 PM 2011 Medical 4b. City Town, or L. 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death DITA Baltinoir C 4024 N/A If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 89 Year 922 248-20-5663 1 M M 2 D F Months Days Hours Min. August 10, South Carolina Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Baltimore N/A 1 Yes 2 No MD 5 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 21223 2 North Smallwood Street Apt. 217 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: B.lack 3 Midowed 4 ☐ Divorced If Yes. Give Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene.
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Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal dea 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform Hospital or Attending Physician: The certificate 2 A No 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this To the Hospur...
within 24 hours after death.
To the Funeral Director: After thi
"maleted filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D 0055 o completed cause of death (Item 23a) (Type, Print) BATTIMOSE X. BATTIMOIC, MD State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:03 A M october 19, 2019 Lynne Primrose Cheryl Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 7 Age (In vrs. last hirthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Hours Washington, 1 □ M 2 💢 F Yrs. Director 1962 212-76-5014 Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No Woodbine MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21797 2974 Jennings Chapel Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc þ ō 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: White Completed 3 Widowed 4 N Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Restaurant Hostess other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked ot traumatic ever ၉ Christine Collins Walter Champ Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2974 Jennings Chapel Rd. Woodbine, MD 21797 19a. Informant's Name/Relationship (Type, Print) of Health a item 27 i Ryan Primrose/daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 5 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State cemetery, crematory or other place, ò Department o Important: If any injury or Final Journey Crematory 10/21/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD Signature of Funeral Service License 21029 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faildre. List only one cause on each line. Approximate Interval Between Onset and Death 1993 Immediate Cause (Final Ph_sician/ COMPLICATIONS OF QUADRAPI disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, board, to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CAL EXAMINE Examine Due to for as a consequence of burial-transit APPROVED BY and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 SEIZURE DISORDER 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? RECURRENT URINARY INFECTIONS 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) 1 Nes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred hours after death. uneral Director: After 5 Pending Natural MOTOR NEHICLE CRASH INTO A TREE 1 ☐ Yes 2 🔀 No 2 Accident Investigation Could not be OCTOBER 10,1993 UNKNOWN filled in by the 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 6LD ANNAPOLIS ROAD determined STREET AND OLD WOODBINE ROAD Hospital 24 hours Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 2 To the F 29c. License number) 64395 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar CEDAR LANE

6336

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIELLE DOBERMAN, MO

31. Date filed (Month, Day, Year)

2 6 2011

OCTOBER 19, 2011

COLUMBIA, MO 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18, 2011 OCT. CURTIS JON PENNINGTON Medical 11:25p M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death MANORCARE ROSSVILLE ROSEDALE BALTIMORE Social Security Number . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth F£B^{nth, Day} 7^{ear)} 1962 **Funeral** If Under 24 Hrs. g. Birthplace (State or Foreign Days 1 🛛 M 2 🗆 F Months Hours 219-80-3695 Director 49 MARYLAND Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD N/A 1

Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? is marked other than "natural", or items 23a Funeral 703 S. BOULDIN STREET 21224 U.S.A. 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Completed by 1 XNever Married 2 Married Black, White, etc. Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 🗆 Widowed 4 🗆 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LABORER GENERAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည RAYMOND PENNINGTON NANCY JUNE VIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 N.JUNE PENNINGTON/ MOTHER 703 S. BOULDIN STREET, BALTIMORE, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 10/25/11 BALTIMORE, MARYLAND 21. Signature of Fund Pervice Licensee TLLY & ETTER INC. FUNERAL HOME 00 S. CONKLING STREET, BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events. Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ☐ Yes ∠ ☐ ☐ Unknown been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician; The law requires the within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 🔲 🌿 2 🗆 No 3 🗆 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🔲 Yes 2 ဂ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier MD D69540 20/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SWIE 204 Parkville MD 21234 wall word State 6 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year RICHARDSON THERZSA Medical 10 01:49 A 2011 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Haspital Baltimore Baltimere **Funeral** 5. Social Security Number 6. Sex Age (In vrs. last birthday 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 XF Months Days Hours Min. th, Day, Year) Jan 30, 1937 Director 216-34-3180 NC Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: In iting 70 rother traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD **Anne Arundel Baltimore** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Round Road 21225 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed 3 Widowed 4 Divorced Specify: Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Nurse Aide** Hospital 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Joseph Minnie Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Elmore 2808 Bookert Drive, Brooklyn, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Oct 20, 2011 Catonsville, Maryland Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 otle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Massire Medical Due to (or as a consequence of) Examiner than 10/a Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed ongestine Heart and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Feilare Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Ves 2 No 2 NO within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide 1 Yes Investigation 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number RES OO October, 14th 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 St. South Hanover Baltimore 21225 31. Date filed (Month, Day, Year) -State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34120 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20, 2011 5:05 P. M Mildred F. Reuwer Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner Baltimore** 5205 Leeds Avenue Arbutus If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 94 Months (Month, Day, Country)
Maryland 215-09-5439 917 Director Aug Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD Baltimore Arbutus 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö must be r Funeral 5205 Leeds Avenue 21227 USA "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death be peartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Dry Cleaners Owner/Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Elsie Heminia Kruse Harry Midgely Fretwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Letitia M. Reuwer, Daughter 5205 Leeds Avenue; Halethorpe, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date Department of H Important: If ite any injury or otl once. 1 X Burial 2 Cremation 3 Removal from State 10/25/201 Lorraine Park Cemetery Woodlawn, MD Donation 5 D Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Lice 21228 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line alteropelestic Immediate Cause (Final Physician/ xen disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy has death?
1 Yes 2 No certificate Yes 2 V No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural Investigation Accident 24 hours after deatle Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, in by 1 4 Homicide determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) athber 21, 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 2122 1001 Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Tammy Jane	Sturgeon
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1-07780 ammy Jane Sturge			n Black Indelible and / Department of						.egibl	le.				
	1- For State Registrar	tate of Maryi	Certificate of		and	Wichte	41 1 1 y	gicric	Reg. No	. 20			341	-
Physician/ Medical Examiner	Physician/ 1. Decedent's Name (First, Middle, Last) Tammy Jane Spurgeon						1	2. Date of D Month October	Day	Year 011			e of Death 23 hrs	
)	4a. Facility Name (if not instituti 102 Hopkins Road		umber)	4b. City, Tov Baltimo		ocation of I	Death			c. County of Baltimore				
Funeral Director	5. Social Security Number 434-23-9259	6. Sex	7. Age (In yrs. last birthday) 52 y	If Under Months	1 Year Days	If Under 2 Hours	24Hrs. Min.	8. Date of Jan.	Birth(MN		Foreig	n	(State or Dakota	1

10c. City, Town or Location

Baltimore

12. Was Decedent Ever in U.S.

2 X No

Armed Forces?

College (1-4 or 5+)

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Live birth

28a. Date of Injury (Month, Day, Year)

9 Unknown

23c. If yes, outcome of pregnancy

Pregnant at time of death

2

28b. Time of Injury

fd 7:00 pm

Found: Residence

Yes

5+

(Sister)

2 Cremation 3 Removal from State

f Yes, Give Year

10f. Zip Code

21212

13. Was Decedent of Hispanic Drigin? (Specify Yes or No-

iten 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. hours after death with the Maryland Director Funeral 至 Completed

Usual Residence of Decedent

102 Hopkins Road

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Susan J. Myers

20a. Method of Disposition

1 X Burtal

David Dale Spurgeon

4 Donation 5 Other Specify.

ignatur of Funeral Servi Licen

muni

Immediate Cause (Final disease

or condition resulting in death)

Sequentially list conditions,

if any, leading to immediate

X UNPENDED

past 12 months?

1 Yes

1 Natural

1 Yes 2 No 9 V Unknown

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

failure. List only one cause on each line

19a. Informant's Name/Relationship (Type, Print)

Maryland

11. Marital Status

10e. Street and Number

1 Never Married

10b. County

Baltimore

2 Married

4 ADivorced

15. Decedent's Education (Specify only highest grade completed)

Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural",
injury or other traumatic event, the Mailcal Examiner

8

Division of Vital Records, P.O. Box 68760,

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transi the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: the f completely filled in by

Certification: ca

Physician Medical Ėxaminer Examine Physician/Medical <u>۾</u> Completed Be

IF FFMALE 23b. Was decedent pregnant in the 25. Was case referred to medical 27. Manner of Death

5 Pending fd 10-16-11 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 K Could not be 3 Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

26

Ling Li, MD

Registrar's Signature ORIGINAL

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White 1 Yes 2 X No specify: Specify: 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Medical Doctor 18.Mother's Name (First, Middle, Maiden Surname) Barbara Copeland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oak Park, CA 91377 5435 E. Napoleon 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 10/21/2011 Lakewood Cemeterv Bowling Green, VA 22 Name and Address of Facility
Storke Funeral Service, Inc
P.O. Box 920 Bowling Green, Inc. VA 22427 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and a Quetiapine Intoxication AMENDED 23a,27,28a-f.per me,g921 11-21-11 sm #1perME,G920,10/26/2011,WS 23d. Date of delivery Year 3 Ectopic pregnancy Month Dav Fetal death 5 Other (Specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an

unknown

autopsy

performed?

Yes 2 No

Other Nursing Home 5 Residence 6 Other: Scene

Baltimore,MD

28d. Describe how injury occurred

10d. Inside City Limits

1 Yes 2 X No

10g. Citizen of What Country?

White, etc.

14. Race - American Indian, Black,

24b. Were autopsy findings available

death? 1 🗸 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State) 102 Hopkins Rd.

October 17, 2011

29d. Date signed (Month, Day, Year)

prior to completion of cause of

2 No

U.S.A.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

26.Place of Death (Check only one)

28c. Injury at Work?

1 Yes 2 X No

OCME

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and Martificate of Death	1ental Hygi	•	31.122
	Dh:-:-	/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	12 0 1 1	3. Time of Death
nen ,	Physicia Medic		Elizabeth Crawford Swank		October	20, 2011	7:25 AM
	Examir	ner	4a. Facility Name (if not institution, give street and number) Fort Washington Health & Rehab	4b. City, Town, or Location of Death Fort Washington		4c. County of Death Prince G	acres!c
	Funeral	г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	<u> </u>	place (State or Foreign
	Director		242-12-4882	Months Days Hours Min.	Sept. 27	, 1917 Sou	th Carolina
	and show	ō	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryl 28a-f otifiec	Director	Maryland Charles Indian He	ad			1 🗌 Yes 2 ဳ No
	th the	a D	10e. Street and Number	10f. Zip Code		g. Citizen of What Coul	ntry?
	ath wi	Funeral	3830 Livingston Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20640 Was Decedent of Hispanic Origin? (Spe		J.S.A.	
9	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Ex®miner must be notified at		Armed Forces?	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	14. Race - American Indian, Black, White, etc.	
003	urs aff tural", al Exe	ted	Year or Dates.	1 ☐ Yes 2 🛣 No Specify:		Specify: Whi	te
15-	72 ho n "nat Aedica	Completed by	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workin O NOT use retired)	ng 1	6b. Kind of Business In-	dustry
212	within giene. er tha	ပိ	Elementary/Seconday (0-12) College (1-4 or 5+)	Nurse		Healthcare	•
pu	Hy oth ent	To Be	17. Father's Name (First, Middle, Last)	(First, Middle, Ma	iden Surname)		
<u>y</u> a	should be fil n and Mental r is marked of raumatic ev	-	James William Crawford	Mamie W			
Baltimore, Maryland 21215-0036	d 2 shc alth an 27 is ir traui		Cilbort Ing Pausarman (Nambara)	ng Address (Street and Number or Rural Livingston Rd., I			
ore,	of Her of Her if item		20a. Method of Disposition 20b. Place of Dispo			0c. Location - City or To	
ţ	t. Page trent rtant:		4 □ Ponation 5 □ Other (Specify) Meadowbre	ook Mem. Gardens10,		Suffolk,	
Ba	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Once.	33.55		3 Name and Address of Facility eninsula Funeral 1 11144 Warwick Blvd	***		23601
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode of dying, such as cardiac or	r respiratory arrest		Approximate Interval Between
	Pnysician/ Medical		disease or condition resulting in death) Arteriosclerotic Due to (or as a consequence of):	Heart Disease		_	Onset and Death
-	Examiner						
_	ol d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Early weighting Cause Disease or linjury				
	xecute n and al-trans	Exar	Cause (Disease or Injury that initiated events c. Due to (or as a consequence of):				
8	aath certificate be executed attending physician and for use as the burial-transit	ical	d				
3876	rtificat ing ph e as th	/Mec	IF FEMALE:				
ox 6	ath ce attend for us	cian,	23b. Was decedent pregnant in the past 12 months? 1 2 1 Pregnant 2 Fetal death 3 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
P.O. Box 68760	the de by the ached	Physician/Med	1 Yes 2 No 4 Pregnant at time of death 5 L 9 Unknown 9 Unknown	- Cities (specify)			
Ä.	s that gned k	by	Part II. Other significant conditions contributing to death but not resulting in the t	inderlying cause given in Part I.		cco use contribute to th	
rds	require	eted				2 🗓 No 3 🗆 Prot	
Division of Vital Records,	The law cate has be page 2 s	Completed			24a. Was an autopsy performe	prior to co	osy findings available mpletion of cause of
<u>a</u>	ian: Th		25. Was case referred to medical examiner?	26. Place of Death (Check	performe 1 Yes 2 only one)	X No 1 ☐ Yes	2 🗆 No
₹	hysic this ce al direc	은	1 ☐ Yes 2 ♣ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	nt 3 DOA Other: 4 Nursing Hon	ne 5 🗆 Residend	ce 6 Other (Specify)
ㅁ	ding F th. After 1 funera	cate:	27. Manner of Death 1 🖾 Natural 5 🗌 Pending 2 🗋 Accident Investigation		8d. Describe how		
1810	er dear ector: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str			et and Number or Rural	Route Number,
2	oital or urs aft ral Dir		building, etc. (Specify)		City or Town, S	,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check conly one) 2 Certifying Physician: To the best of my knowledge, death of the best of my knowledge,	tigation, in my opinion, death occurred at t death occurred at the time, date and place	the time, date and I	place, and due to the cau	use(s) and manner stated.
	7 wit		29b. Signature and title of contifier William Canner my	29c. License number D35206		i. Date signed (Month, L $ct. 21, 201$	
	10		30. Name and address of person who completed cause of death (item 23a) (Type, F William T. Tanner, M.D. 11701	Livingston Rd., F	t. Washi	ngton, MD	
E	Stat Registra	e ır	31. Date filed (Month, Day, Year) OCT 2 6 2011 Registrar's Signature	plas			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Samue o tober Physician/ 18:30 PM Medical 4a. Facility Name (if not institution, Examiner give street and number City, Town, or Location of Death 4c. County of Death Johns HOPKINS Baltimore HOSPITA 5. Social Security Number last birthday If Under Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Hours Country) 580-04-7509 **Director** 1**X** M 2 □ F 65 Oct. 31, 1945 St. Lucia, VI Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 X Yes 2 No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7704 Hyacinth Court 20707 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 ☐ Yes 2 📉 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", o Medical Exan 1 ☐ Yes 2 🔀 No Specify. Completed 3 Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72. h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Process Operator Refinery traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walton Adams Mildred Samuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Yolander Deterville -Daughter PO Box 2339, Frederiksted, VI 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō permit. Page 1 Department of Important: If ii any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Kingshill Cemetery 10-27-2011 Frederiksted, VI Donation 5 Other (Specify 21. Sigr 22. Name and Address of Facility
James Memorial Funeral Home
611 LaGrande Princess, St. ture of Funeral Service Licentee hun Croix, US, VI 00820 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Pneumonia Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin that initiated events resulting in death) Last physician ar the burial-t Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law autopsy page perforn Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital pital: 1 Inpatient 2 2 28a. Date of injury မ 1 Yes 2 No Other: After this ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this
filled in by the funeral di 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending Investigation 1 Yes 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hound to the Funer completely fi 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cortifles 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, mp 2128 SONALI 31. Date filed (Month, Day, Year, barker State 32. Registrar's Sanature 26 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ at fober 201 18:15 MARY illiams Medical 4a. Facility Name (if not institution, give street and number, Examiner County of Death HOPKINS Hosp, tal baltimore JOHNS N/ASocial Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 1 🗆 M 2 🗶 F 212-60-3650 49 May 19,1952 Virginia Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified N/A MD Baltimore 1 X Yes 2 No 9 10e. Street and Number 10g. Citizen of What Country? must be Funeral 23a 5504 Cedonia Avenue 21206 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö by 1 Never Married 2 Married 1 Yes XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural" Completed 3 X Widowed 4 ☐ Divorced Specify. Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 1oth Grade Catholic Charities <u>Health Care Provider</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Andrew Long other traumatic Frances Smith Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosea Blackwell/ Daughter 5504 Cedonia Avenue Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Greenmount Cemetery 10/19/11 Baltimore, MD 21. Signature Funeral Service Licenses 22. Name and Address of FacilityChatman-Harris Funeral Home arrie 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate
Cause (Disease or injury Due to (or a a consequence of) Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No the detached Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate I 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: မ Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral Director: After the din by the funeral 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending injury work?
1 Yes 2 No 2 Accident Investigation within 24 hours are: ...
To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Continuing Number Prantition of To the could be a provided at the time, date and place and due to the cause(s) and manner and time. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD 442928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Garcia 31. Date filed (Month, Day, Year, Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Edward Stefanowitz 10/23/2011 4:40ant Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall VA Home Charlotte Hall St Marys If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 034-05-9795 Age (In yrs. last birthday) 8. Date of Birth Days 1 X M 2 - F 91 **Director** 871471920 Yrs. MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 Yes 2 No 10e. Street and Number 1601 Webster Street 10g. Citizen of What Country? 10f. Zip Code 21230 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No Guard
If Yes, Give
Year or Dates. WWII 11, Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 ☐ Divorced White the Me ical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Sunpaper Composer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Stefanowitz Mary Unk. 19a. Informant's Name/Relationship (Type, Print)
Michael G. Stefanowitz /Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Caldera Ct, Westminster MD 21158 Department of Health a Important: If item 27 is any injury or other tran 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/28/2011 Baltimore Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last as the burialphysician Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an this certificate has page 2 autopsy prior to completion of cause of the Hospital or Attending Physician; The hin 24 hours after death. 1 ☐ Yes 2 ☐ No 🗌 Yes 2 🛂 Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ 1 Tyes Other 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be within 24 hours after death To the Funeral Director: Suicide 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the bost of my knowledge 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) affelis 100 Hose Prive Prive Frederik mo mo 31. Date filed (Month, Day, Year) **OCT 2 6 201** State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Antonia Santiago 7:30am Medical 4c. County of Death

Carroll 4a. Facility Name (if not institution, give street and number)
Briton Woods Nursing Home 4b. City, Town, or Location of Death Examiner Sykesville If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 220–48–1074 **Funeral** (Month, Day, Year) 5/19/26 1 □ M 2 🔀 F Months Days Hours Director Usual Residence of Decedent Rico 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location Examiner must be notified at Director MD Carroll Sykesville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 21784 **USA** 23a 1442 Buckhorn Road items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 2 Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ument of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1XXYes 2 ☐ No Specify: Specify. 3 Widowed 4 Divorced th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last)
Unknown 18. Mother's Name (First, Middle, Maiden Surname) ျှ DeJesus Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Santiago /Daughter 418 Poole Road #B4, Westminster MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State Florida National Cemetery 10/31/2011, Bushnell, 4 Donation 5 Other (Specify) Doda, Jr. Charles L. Stevens Funeral Home, 1501 E. Fort Ave, Baltimore MD 21 celicense Victor P. 23a, Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Klud disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? for Pregnant at time of death led by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, I 25. Was case referred to predical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date stoned (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 CRNSu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Schwarzmann 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Baltimore Charlestown Care Center Catonsville If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, 29, 1 1 □ M 2 👿 F Months Days Hours 220-09-5275 Director Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral 709 Maiden Choice Lane 21228 USA be filed within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: If Yes, Give 'natural", 3 Divorced 4 Divorced Completed Year or Dates and Mental Hygiene. is marked other than "natur raumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Kemler John A. Harman Page 1 and 2 should nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
719 Maiden Choice Lane, BR515; Catonsville, MD 21228 George F. Schwarzmann Husband 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of i
Important: If it
any injury or of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Mem.Gar.10/28/2011 Timonium, MD 4 Donation 5 Other (Specify) Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licensee Funeral Home of Catonsville, Inc Hackma 630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End-Stage disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician Physician/Medical certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Day Month Year Pregnant at time of death ed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by The law requires Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier Ren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/I Days Hours Min. NOV. 25 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	201 34 2 Year 3. Time of Death
Physician/ 1. Decedent's Name (First, Middle, Last) THOMAS STUCKER, JR 4a. Facility Name (if not institution, give street and number) 603 S. Ann Street 5. Social Security Number 212-46-3027 1XM 2F 66 Yrs. 4b. City, Town, or Location of Death Baltimore 5. Social Security Number 212-46-3027 1XM 2F 66 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Vear
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는 문화를 보고 1 IN/A I BALTILIMODE	10d. Inside City Limits 1 X Yes 2 No
MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citiz	zen of What Country?
MD N/A BALTIMORE 10e. Street and Number 10e. Street and Number 10g. Citiz	U.S.A.
11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	 Race - American Indian, Black, White, etc.
1	Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. K	Kind of Business/Industry
15. Decedent's Social Occupation (Give kind of work done during most of working life. Do NOT use retired) SANITATION DEPT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden)	ALTIMORE CITY
PROPERTY OF THE PROPERTY OF TH	
ANN MIZERAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Ci	
MILDRED M. SOBUS/SISTER 1724 SEARLES RD., DUNDALK, MA 20a. Method of Disposition [20b. Place of Disposition (Name of cemetery, Date 20c. III) [20c. III]	ARYLAND 21222 Location - City or Town, State
20c. Lead of Disposition (Name of Cemetery, crematory or other place) 20c. Place of Disposition (Name of Cemetery, crematory or other place) 20c. Leading the leading of Disposition (Name of Cemetery, crematory or other place) 20c. Leading the leading of Disposition (Name of Cemetery, crematory or other place) 20c. Leading the leading of Disposition (Name of Cemetery, crematory or other place) 20c. Leading the leading the leading of Disposition (Name of Cemetery, crematory or other place) 20c. Leading the leadin	,
BAYVIEW CREMATORY 10/17/11 BAI	LTIMORE, MARYLAND
1901 EASTERN AVENUE, BAL'	ERAL HOME TO.,MD 21231
failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	
Sequentially list conditions, b	
if any, leading to immediate Course. Enter Underlying Course (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
na la	
AMENDED 23a, 27, per me, g921 11-18-11 sm Section is a section of the section of	
9 by Companies of the c	d. Date of delivery Month Day Year
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M के के के कि Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco	use contribute to the cause of death?
O at 2 a 2 a 2	No 3 Probably 4 ✓ Unknown
C. Later 18 de la	24h Were autopsy findings available
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23e. Did tobacov 1 1	prior to completion of cause of death?
25. Was case referred to medical examiner? 1	prior to completion of cause of death? 1 ✓ Yes 2 No noce 6 ✓ Other: Scene
25. Did toback 1	prior to completion of cause of death? 1 ✓ Yes 2 No noce 6 ✓ Other: Scene
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29b. Signature and title of certifier 29c. License number O.C.M.E. October 1 30. Name and address of person who completed cause of death (Item 23a) D. Roman and Complete Course of death (Item 23a) October 1 October 2 October 3 October 4 October 3 October 4 Octobe	prior to completion of cause of death? I Yes 2 No Prior to completion of cause of death? Yes 2 No Prior to completion of cause of the cause of t
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11: 40 A.M Physician/ Detober John e. Stumpf, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Center Baltimore Washington Medical <u>Glen Burnie</u> Arunde l If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) Year **Funeral** 1**x** M 2 □ F (Month, Day, Davs Hours Year! Country **Director** 86 1925 219-16-0080 Maryland Usual Residence of Decedent 28a-f show 10a, State filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Yes 2X No <u>Maryland</u> Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 289 Thelma Ave 21061 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. 44–46 Black, White, etc. p 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hyghene.
Important: If item 27 is marked other than "ni
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chessie Railroad Systems Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John E. Stumpf, Sr. Mildred Jeannette Peddicord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thlema Ave. Glen Burnie. MdJohn E.Stumpf/son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial | 10/27/2011 | Glen Burnie, MD 21. Signature of Funeral & rvic Censee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home Crain Highway, S.E., Cl mode of dyin, such as cardiac or respiratory arrest, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying Approximate shock, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (**Examiner** Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Yes g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by signe be (2 No 3 ☐ Probably 4 ☐ Unknown Records. 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 A\No page 2 s 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 2 X No Hospital Other: 1 Yes ၉ 1 X Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury Month, Day, Year) Magner of De 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider injury 5 Pending death. 1 Tyes 2 No Accident Investigation after death Director: / 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined in 24 hour.
o the Funeral Discompleted filler Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryland		artment of F <i>tificate of E</i>		and M		giene Reg. No 20	1.1	341	30
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	with th 23a o 1st be	eral	3820 W. Coldspi	ing Lane			10f. Zip Code	1215			10g. Citizen of V		try?	
	e filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status unl	12. Was Decedent Eve		. If	Vas Decedent of His Yes, specify Cuba	spanic Orig	in? (Spec	cify Yes or No-	14. Rac	e - Americ		
36	after al", or Examir	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give	o un	.K	Yes 2 No		1 00101	noan, cro.,	Specify:	blac		
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once.		21. Signatur 14 Funeral Service lice	May pigg	ctor		Name and Address	_			. Baltin	nore	Street	
			23a. Park 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused the	he death. D		altimore , rthe mode of dying		2120 ardiac or		est,		Approximate	
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Division of Vital Records, P.O. Box 68	ne dear / the at ched fa	Physician/M	1 Yes 2 No	4 ☐ Pregnant at ti 9 ☐ Unknown	ime of deatl	h 5 🗌	Other (specify)				Mos	nth	Day Ye	ar
P.0	that the	by P	Part II. Other significant conditions	contributing to death but	not resultin	g in the ur	nderlying cause give	en in Part I.		23e. Did to	bacco use contr	ibute to th	e cause of dea	ath?
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<u>≤</u>	ital or urs afte ral Dir lled in		20.0111110	building, etc. (Specify)					City or Tow	n, State)			
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	ledical	(Check 2 L Medical Exar	ysician: To the best of my niner: On the basis of exar	mination and	d/or investig	gation, in my opinior	, death occ	urred at tl	ne time, date ar	nd place, and due	to the cau	se(s) and manr	ner stated.
:	To the To the compl	Σ	20h Signatura and title of partifier	rse Practitioner: To the b	est of my kr	nowleage, o	29c. License	number	_		29d. Date signed	(Month, D	lay, Year)	
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			30. Name and address of person who N " S - Ra) ~ paktly	completed cause of deat M·D 783 5	th (Item 23a	(Type, Pr	int) 5 Za	03 6	Part	more	ND SI	20	9	
E	Stat Registra	e r	31. Date filed (Month, Day, Year) OCT 2 6 20	3. Registrar's	Signature	bar	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death . Decedent's Name (First, Middle, **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 12/09/1950 Birthplace (State or Foreign Country)
 Nory Land If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Min **Funeral** 1 □ M 2 🕅 F 60 218-58-6615 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1√ Yes 2 □ No Directo Maryland Raltimore N/A 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō United States 21224 314 S. Robinson Street items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", or Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Retail Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I Mildred Lingerman Claude Morris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 states to Department of Health ar Important: If item 27 Is any injury or other trauonce. 314 S. Robinson Street Baltimore, Maryland 21224 John Testerman - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 10/25/2011 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) David J. Weber Funeral Homes P.A. 401 S. Chester Street Paltimore, Maryland 21231 of Funeral Service Licenses Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause the each lin. Approximate Interval Between 3a. Part 1. Enter the cises shock, or heart failure. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ue to (or as a consequence of) The law requires that the death certificate be executed that initiated events the burial-trai and Due to (or as a consequence of) resulting in death) Last P.O. Box 68760, Physician/Medical use as IE EEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, Yes 2 No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tyes 1 □ Yes certificate 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 🗆 Inpatient ER/Outpatient 3 DOA 1 🗌 Yes မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation Injury Natural М 1 Yes 2 No death. Accident after death.

Director: A
d in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pumpler stated. Medical one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of mpleted cause of death (Item 23a) (Type, Print) and address of person wy 200 4940 Eastern Avenue, Baltimore, MD, 21224 State Registrar

DHMH 17 Rev 1/2001 11595 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryland / De	·		ntal Hygie	ene		
			State Registrar		Certificate of L			. No.20	34132	
	Physicia	an/	Decedent's Name (First, Middle, Last) SAMUIL K	TSEYTLOV	CVTV		Date of Death	24, 201 ^{Year}	3. Time of Death 9:55 A M	
d	Medic Examir		4a. Facility Name (if not institution, give stre			Location of Death	CIODER 2	4c. County of De		
كمسين	Å.		NORTHWEST HOSPITA			LSTOWN	i	BALTIN		
	Funeral	Г	5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	ay) If Under 1 Year Months Days		Date of Birth (Month, Day, Yea	9. E	Sirthplace (State or Foreign Country)	
	Director		213-51-5995 Usual Residence of Decedent	^{1 2 □} F 88 Yr	s.		06/16/19		RUSSIA	
	land shov dat	호	10a, State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits	
	Mary 28a-1 otifie	irec	MD BALTIMOR	RE BALT	TIMORE				1 ☐ Yes 2 🔀 No	
	ith the	ral	10e. Street and Number	II #210	10f. Zip Code	0.0	10g	. Citizen of What (Country?	
	ems 2	Funeral Director	1500 BEDFORD AVENU	Was Decedent Ever in U.S.	212	U8 ispanic Origin? (Specify	Yes or No-	USA	nerican Indian,	
စ္က	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☒ No	If Yes, specify Cuba	n, Mexican, Puerto Rica	an, etc.)		k, White, etc.	
00	ours a	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 2 ☒ No Specify: Decedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired)			Specify:	WHITE	
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212	within giene.		Elementary/Secondary (0-12)	College (1-4 or 5+)	ENGINEER			AUTOMOB	ILE	
Maryland 21215-0036	filed all Hy	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fi	irst, Middle, Maid	,		
17/2	of and 2 should be fill the alth and Mental fitem 27 is marked or other traumatic ever	_	CHAIM 19a. Informant's Name/Relationship (Type,	TSEYTLOVSK		PESYA			IKNOWN	
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ore,	ge 1 and t of Hea If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	20b. Place of D	isposition (Name of crematory or other place	Date		c. Location - City		
altimore,	ment tant; I		4 ☐ Donation 5 ☐ Other (Specify)	noval from State ART TN	GTON CHIZU		2011	BALTIMO	RE, MD	
Bal	permit. Page 1 Department of Important; If i any injury or once.		21. Signature of Funeral Service Licenses		22. Name and Addres	ВОД		ON & BROS	·	
			23a. Part 1. Enter the disease, or complica	tions that caused the death. Do not		ERSTOWN ROAD, such as cardiac or res		ESVILLE,	MD 21208 Approximate	
	Ph_sician/		shock, or heart failure. List only one commediate Cause (Final	ause on each line. ACUTE RESPIRA			-,,		Interval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):		KE			-	
137	LXammer	ē	Sequentially list conditions, b.	PNEUMONIA						
	ted Insit	Examiner	if any leading to in mediate cause. Enter Underlying Cause (Disease or injury	Exist to (or as a nonsequence of):					1	
	execu an and rial-tra	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of):						
09	ate be executed ohysician and the burial-transit	dical	d							
P.O. Box 687	ertifica ding p se as 1	/Me	IF FEMALE:	If yes, outcome of pregnancy						
XO	is that the death certification by the attending E be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 2 ☐ Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	у		23d. Date of o	lelivery Day Year	
O. B	the di by the tached	hys	9 🗌 Unknown	9 Unknown						
Э.	es that igned be de		Part II. Other significant conditions contril CORONARY ARTERY		he underlying cause giv	en in Part I.			to the cause of death?	
rds	require been signal	eted		DIBEADE					Probably 4 X Unknown	
ecc	e law e has l	Completed by	SEPSIS				24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of	
<u>=</u>	an: Th tificata tor, pa		25. Was case referred to medical		26. Pl	ace of Death (Check onl	performed 1 Yes 2 2	No 1 □ Y	es 2 No	
<u>K</u>	Physici this cer ral direc	To B	examiner? 1 Yes 2 No	oital: 1 🐰 Inpatient 2 🗆 ER/Outpa	2.1			e 6 Other (Spe	ecify)	
n of	ding P I. After ti funera	ate:	1 Natural 5 ☐ Pending	28a. Date of injury 28b. Tim (Month, Day, Year) inju	ry work	?	Describe how in	njury occurred		
siol	Attenor r death ctor; of the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm,		Yes 2 No	Location (Street	t and Number or F	ural Route Number,	
Division of Vital Records,	tal or A s after al Direc ed in by		4 - Homiciae aeterminea	building, etc. (Specify)	,,,		City or Town, St		ara risate rtambor,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within the Abnours after death. To the Funeral Director, there this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physicial 2 Medical Examiner:	n: To the best of my knowledge, dea On the basis of examination and/or in	ath occurred at the time	, date and place, and do	ue to the cause(s) and manner as lace, and due to the	stated. e cause(s) and manner stated.	
	o the	1	only one) 3 L Certifying Nurse Pr	actitioner: To the best of my knowled	dge, death occurred at to	ne time, date and place, a	and due to the ca	ause(s) and manner Date signed (Mor	as stated.	
	-> - 0		> Mariny	HYSICIAN	D42			OCTOBER 2		
			30. Name and address of person who comp	leted cause of death (Item 23a) (Typ	e, Print)					
سي	Stat		DR. HARISH, NORTHWE			LD COURT RO	DAD, RAN	NDALLSTOV	VN, MD 21133	
	Registra	ır	31. Date filed (Month, Day, Year) OCT 2 6 2011	32. Registrar's Signature	Ker					

DHMH 17 Rev 06-2011

11-07934 Charles Valentin	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. entine State of Maryland / Department of Health and Mental Hygiene Certificate of Death									
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		or Death	2. Date of D	Reg. No.	3. Time of Death			
Medical Exami		Charles Valenti				Day Year r 21, 2011	2207 hrs			
.		4a. Facility Name (if not institution, give street and nu University Hospital 5. Social Security Number	7. Age (In yrs. last birthday)	4b. City, Town, or Location Baltimore If Under 1 Year If Und		4c. County of Dea	irthplace (State or			
Funeral Director		216-86-1508 13M 2 F	36	Months Days Hours		/29/74 Fore				
Aaryland 28a-f show any 1 at once,	7	10a. State MD 10b. County Baltimore	10c. City, Town or Loc	Halethorpe		,	10d. Inside City Limits 1 Yes 2 X No			
vith the Maryland 23a or 28a-f show : notified at once.	Director	10e. Street and Number 3177 Bero Road		10f. Zip Code 21 227		10g. Citizen of What Co	- ·			
r death w	by Funeral	1 Never Married 2 Married 1 Armed For 1 Yes If Yes, Give Yea or Dates:	orces? If 2 XX No 1 1	Vas Decedent of Hispanic Ori Yes, specify Cuban, Mexican Yes 2 No specify: ent's Usual Occupation (Give	n, Puerto Rican, etc.)	White, etc.	nican Indian, Black, White			
1/215-0036 d be filed within 72 hours afte fental Hygene. narked other than "natural", event, the Medical Examine	Completed	15. Decedent's Education (Specify only highest grad Elementary/Secondary (0-12) College (1 12 0	-4 or 5+) during	most of working life. DO NOT	use retired)		Service			
21215-0036 wild be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	17. Father's Name (First, Middle, Last) Charles E. Valentine	•	Cat		I. Tresize				
MD 2 id 2 shoul lith and M n 27 is m	입	19a. Informant's Name/Relationship (Type, Print) Toni L. Valentine / W.	ife 317	ng Address (Street and Nur 7 Bero Road, F	Halethorpe	MD 21227	e, Zip Code)			
Baltimore, permit. Pages 1 and Department of Heal Important: If item injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fro 4 Donation 5 Other Specify:		osition (Name of cemetery, other place) Crematory	Date 10/25/1	20c. Location - City of Hanover M				
Balti permit. Departm Importa		21 Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart								
Physician /Medical	failure. List only one cause on each line, Multiple Injuries									
Examiner		or condition resulting in death) Due to (or as a	consequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	consequence of:							
executed an and al - transit		d.	consequence of):				<u> </u>			
= o .g.⊑	Medic	UNPENDED AMENDED IF FEMALE: 23c. If yes, 6	outcome of pregnancy			23d. Date of deliver	1			
certi ndin		23b. Was decedent pregnant in the past 12 months?	orth 2 F ant at time of death 5 (Tetal death 3 Ectopic Other (Specify)	c pregnancy	Month	Day Year			
Records, P.O. Box The law requires that the death icate has been signed by the atte page 2 should be detached for u	by Phy	Part II. Other significant conditions contributing to		underlying cause given in Pa		d tobacco use contribute to				
Ords, I w requires as been sig	Completed				 24a. Wa au	as an 24b. Were a prior to	utopsy findings available completion of cause of			
tal Rec	S	25. Was case referred to medical		OC Plans of Dooth	1. ✓ Ye	rformed? death? s 2 No 1 Y	es 2 No			
Vital ysician:	To Be	examiner?	npatient 2 🗹 ER/Outpatie	26.Place of Death		Residence 6 Othe	er:			
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	tion: T	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation		1 Yes 2	Dodostria	n struck by truck				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, str Local Street	eet, factory, office building, et	or Towr	n (Street and Number or R n, State) Road, Halethorpe, MD	ural Route Number, City			
To the Hospita within 24 hours To the Funeral completely fille	dical	29a. Certifier 1 Certifying Physician: To the besone 2 Medical Examiner On the basis of and manner st	f examination and/or investig	·						
• • • • • •	Me	29b. Signature and fitle of certifier		29c. License number O.C.M.E.		29d. Date signed (Mo				
1 GF OCME		30. Name and address of person who completed caus Mary G. Ripple MD. Deputy Chief M	, ,	0 W. Baltimore Street,	, Baltimore, MD		7. S.			
St: Regist		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature				····			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	-	Certificate of D			Reg. No.	
	Dharisis	,	Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	Day Year	3. Time of Death 3
	Physicia Medic	al	Lawrence		ington			Oct. 15		3:45 P M
	Examin	er	4a. Facility Name (if not institution, Prince George		Center	4b. City, Town, or Chever1	Location of Death	1	4c. County of Dea	
- elle	Funeral				e (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	9 B	irthplace (State or Foreign
	Director		223-00-4032	1 △ M 2 ⊔ F	65	Yrs. Months Days	Hours Will.	March 1	1946	Virginia
	nd thow at	l 1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	//aryla 8a-f s tified	rect	VA Prince	William	Woodbr	idge				1 ☐ Yes 2 ☒ No
	a or 2 be no	Ö	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	th wit	Funeral Director	5353 Macwood D	rive	Ever in II S	22193	ispanic Origin? (Si		United Sta	
ယ	or ite	by Fi	11. Marital Status1 ☐ Never Married 2 X Marr	Armed Forces?		13. Was Decedent of H If Yes, specify Cuba		o Rican, etc.)	Black, Wh	ite, etc.
003	ural", ural",	ted t	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No			Specify: B1	
Maryland 21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	(Specify only highe	t's Education st grade completed)		Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	ation during most of wor	rking	16b. Kind of Busines	s Industry
212	within jiene.		Elementary/Seconday (0-12)	College (1-4 or 5)+)	Metro Drive	r		Transport	ation
pu	filed vital Hyg		17. Father's Name (First, Middle, L	ast)				,	Maiden Surname)	
ryla	should be file h and Mental I 7 is marked o traumatic eve	잍	Lloyd J. Washin		1.0	. Mailing Address (Street		E. Toles		Zin Cada)
Ma	2 sho Ith and 27 is r traur		19a. Informant's Name/Relationsh			53 Macwood				
	1 and of Heal item 3		Connie Washingt 20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other place		Date	20c. Location - City	or Town, State
imo	Page 1 nent of ant: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Quanti	co National C	em. Oct	24, 2011	Quantico,	Virginia
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L						nett Funer lericksburg	
	ED = 60	Н	23a. Part 1. Enter the disease, or		moiz84					Approximate
	Physician/		shock, or heart failure. List o Immediate Cause (Final	nly one cause on each line	₽.	MAC ARLHY				Interval Between Onset and Death
٠	Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of	of):				
H	Examiner	Į.	Sequentially list conditions, if any, leading to immediate	b. —						
0	ed ed	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a cońsequence c	01):				
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90	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the bural-transit	Physician/Medical Examiner	d							
68760	ertifica ding pl	/Me	IF FEMALE;	23c. If yes, outcome	of pregnancy				23d. Date of	delivery
Box (attend for us	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 4 Pregnant a	2 Fetal death	n 3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	cy		Month	Day Year
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rds	requir been s should	etec						24a. Was	an 24b. Were	autopsy findings available
ecc	The law ate has page 2 s	Completed						autor perfo 1 Yes	psy prior to prmed? death	to completion of cause of
of Vital Records,	sician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?			26. P	lace of Death (Che		2 100	
Z:t	hysic this ce al direc	은	1 ☐ Yes 2 🗷 No 27. Manner of Death			itpatient 3 DOA Oth	4 L Nursing	1	dence 6 Other (Sp	ecify)
	fing T. After fune	cate	1 Natural 5 Pendin 2 Accident Investig			njury wor		28a. Describe i	now injury occurred	
Division	il or Attending safter death. Director: Affer d in by the funer	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e Place of Ini		rm, street, factory, office		28f. Location (S	Street and Number or I	Rural Route Number,
Ď.	Hospital or 24 hours afte Funeral Dire									
	To the Hospital or vithin 24 hours after To the Funeral Direction completed filled in b	Medical	(Chook / Modical F		examination and/o	or investigation, in my opini	on, death occurred	at the time, date a	and place, and due to the	ne cause(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3 L Certifying 29b. Signature and little of certifier	Nurse Practioner: 10 tre	Dest of my know	29c. Licens	e number	nace, and due to the	29d. Date signed (Mo	
			1 m/	m &	Ans	106	3688		Detoser	17,2011
	6		30 Name and address of person	who completed cause of c	death (Item 23a) (Type, Print) SPITM DEIL Sauls Saul	E CHE	FLLY	ND 2078	85
	Sta	te_	GLIFFIN DAVIS 31. Date filed (Month, Day, Year)	MA 32. Registr	ar's Sign	Land 1		- 11	10	
	Registr		31. Date filed (Month, Day, Year) OCT 2 6	UIT Sergera	p. 19. 19	paire				

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10 pm			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend Item 25 per me, g920, 10/26/2011dhb Certificate of Death Reg. No. 20 34 3	
8	M	ician/ edical	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day O-23 O-20 Year O-29	
(Exa	miner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore	4
-	Fune Direc		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Har If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) 9. Country) 9. Country) 9. Country) 9. Country) 9. Country)	
3	3		Usual Residence of Decedent 1 M 2 F 56 Yrs.	4
4	Marylan 28a-f sh	recto	MD Baltimore Sparks 1 Yes 2 RNO	
0	ith the l	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Rain Flaver A. WIv. it 104 21152 USA	١
-	death with the Maryland	Fune	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes specify Cuhan Meyican Puerto Rican etc.) 14. Race - American Indian, If Yes specify Cuhan Meyican Puerto Rican etc.)	٦
1	o36 s after cral", or	ed by	1 Never Married 2 ☐ Married 1 ☐ Yes . 2 ☐ No If Yes, Give Year or Dates.	
ĺ	21215-0036 within 72 hours after giene.	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife. DO NOT use retired) 16b. Kind of Business/Industry	
alk	212-within giene.	Con	Elementary/Secondary (0-12) College (1-4 or 5+) Croundsman Shaw Air Torce Base	\exists
7	laryland 2121 should be filed within 7 and Mental Hygiene.	To Be	17. Father's Name (First, Middle, Last) L.T. Warker 18. Mother's Name (First, Middle, Maiden Surname) Rosa Mae Dickey	
	Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. T is marked of ther than "natural", or items 23a or 28a-f shown in the Medical Exemises must be partitived at the Medical Exemises.		19a. Informant's Name/Relationship (Type, Pri. t) 5 '54c 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. e)	
90		n James d	Mary Walker-Shaw SRain-Path Wit-104 Sparks MD 21152 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	+
, 3	altimore,	io di	112 Burlal 2 Cremation 3 Removal from State Commetery, crematory or other place) 4 Donation 5 Other (Specify) Coolyay Cenetery 10/29/2011 Lyachburg 5 Coolyay Cenetery	
1	Balt permit. Departi	any in	21. Signature of Funera Service Licensee Vame and Address of Facility of the Francisco Service Service Licensee 4903 Vous Address of Facility of the Facilit	
	MAN		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of the g, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between	
	Physici Medi		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death	_
	Exami	ner	Sequentially list conditions, b.	_
	ped ped	Examiner	If any, leading to immediate couse. Enter Underlying Cause (Disease or injury	
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	ox 68760 eath certificate beath certificate by attending physis	ian/N	FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 1	
	b. Bo the dear	be detaction for use as the by Physician/Medi	1 Yes 2 No 9 Unknown 9 Unknown 12 World 13 Yes 2 No 9 Unknown 14 Pregnant at time of death 5 Other (specify) 15 Yes 2 Yes 3 Yes 4 Pregnant at time of death 5 Other (specify) 16 Yes 3 Yes 4 Yes 4 Yes 5 Yes 5 Yes 6 Yes 6	
	ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate or death. extern After this certificate has been signed by the attending physician of the physician of th	I by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? 1 Sec. 2 No. 3 Probably 4 Unknow.	n
	ords v require		24a. Was an autopsy findings available prior to completion of cause of	
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7	O of Valing Phy	ate: T		
8	To the Hospital or Attending Physician: within 24 hours after death.	Medical Certificate:	2 Accident 3 Suicide 4 Homicide Accident Could not be determined M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	1
-	bital or surs after eral Din	Sal Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	-
A	the Hospital hin 24 hours a the Funeral I	Medical Certific		ed.
Ĭ	Vith Vith		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
i			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	_
	۲ 	State	31. Date filed (Marth Parceau and 1 22. Registrar's Signature	
11.	Reg	gistrar	UCI 20 2011 Kenus p. Marie	

Please Type of Print in Flack Indelible 19kp Epstre 412 Copies Are register. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:45 PM 2011 October Loretta Willoughby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Year If Under 24 Hrs. Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year, Davs 217-38-2679
Usual Residence of Decedent 1 🗆 M 2 🟋 F **Director** Yrs Maryland Mar 10, 1942 69 28a-f show 10c. City, Town or Location 10a. State 10b. County 72 hours after death with the Maryland notified at Director 1X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be i Funeral USA 21212 748 Richwood Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates black. Specify: Completed unk the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry than, life. DO NOT use retired) within 7 Elementary/Secondary (0-12) College (1-4 or 5+) State Of Maryland 15 Social Worker n and Mental Hygier Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic other traumatic 19**1 6/1**1/39 **Now**est/Street and **Mandary Rep** Pougraphy City or Town, State, Zip Code)
555 Towsontown Blvd Towson, MD 21204 19a Informant's Name/Relationship (Type, Print) **Leonora Young/Daughter**Gilchrist Hospice Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) XXBurial 2 Cremation 3 Removal from State Crownsville,MD Crownsville Cem. 11/14/2011 4 Donation 5 Other (Specify) 4300 Wabash Ave f Funeral Ser any in Baltimore, MD 21201 21215 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between nset and ath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg Day 5 Other (specify) Pregnant at time of death the £ Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PERTENSION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificate has beral director, page 2 s autopsy performed? 2 🗌 No 1 Yes Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After letely filled in by the funer 1 Natural iniury 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely within 2. only one) 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who c pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

		Please	Type or Print in Black Inc amend, 10c, 10d, per State of Maryland, Depa	delible lnk	K. Ensure All 10-26-11 s Health and M	Copies A	re Legible.	
	•	For State Registrar		tificate of			1. No 2 0 1 1	34137
Physiciar /Medica		1. Decedent's Name (First, Middle, Las	4. Willoughby	/		2. Date of Death Month	Day Year 23 26 11	3. Time of Death
Funeral Director		4a. Facility Name (If not institution, give SAINT AGNES 5. Social Security Number 6. Social Security Number 10a. State 10b. County	HOSPITAL	BALT If Under 1 Year Months Days		8. Date of Birth Month Day,		nplace (State or Foreign untry)
e Mary	CIOL	MD BaHi	more Batti	more	Catonsvi			-1.2 √os 2 No
23a or 2	runeral Director	5906 Mooreh	end Road		228		g. Citizen of What Cor USA	
5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Evanither mast to rectified at		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	1 ☐Yes 2 ☑No	Vas Decedent of Yes, specify Cub □Yes 2 No	Hispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
nd 21215-0036 se filed within 72 hours aft tal Hygiene. d other than "natural", or event, the "hodical Eventi	se completed by	15. Decedent's Ed (Specify only highest grade Elementary/Secondbry (0-12) 17. Father's Name (First, Middle, Mast)	College (1-4or 5+)	ent's Usual Occu kind of work done OO NOT use retire	during most of working	rk 0	State of Business/I	ndustry Maryland
Maryland to 2 should be file tith and Mental Hy 27 is marked oth r traumatic event		19a. Informant's Name/Relationship (7	nor (Son) 19b. Mailin	g Address (Stree	t find Number or Rura	Route Number, (Dith City or Town, State, Z Wille S	(ip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and proce.		20a. Method of Disposition 1 Method of Disposition 1 Method of Disposition 3 Cremation 3 Checking Service Specify 21. Signature of Funeral Service Licenses	Removal from State	sition (Name of natory or other pla	Da		Wings M Leval Ser Ke (212	Town, State ills, MD vices 29)
Physician /Medical Examiner ial-transit		shock, or hear tailure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unidentying Cause (Disease or injury)	a. METASTATIC BLAD Due to (or as a consequence of): Due to (or as a consequence of):		-	respiratory arres	it,	Approximate Interval Between Onset and Death Mon THS
2 8 % 5 -	LYG	resulting in death) Last	c. Due to (or as a consequence of): d					
P.O. Box 6876 hat the death certificate to do by the attending physic letached for use as the behaviorian/Medica	y sicialitim	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ► 0 9 □ Unknown		Ectopic pregnan Other (specify)	су		23d. Date of del Month	ivery Day Year
Records, P.O. e law requires that the dhas been signed by the e.z. should be detached	2		ontributing to death but not resulting in the un	derlying cause gi	ven in Part I.		cco use contribute to 2 ☐ No 3 ☐ Pr	
al Records, The law requires the cate has been signed page 2 should be defined by	חובות	HYDRONEPHROSIS				24a. Was an autopsy	prior to o	topsy findings available completion of cause of
tal Fall Fall Fall Full Fall Fall Fall Fa		Durumonia 25. Was case referred to medical			26. Place of Death		Mo 1 ☐ Yes	2 🗆 No
MGHBY, An of Vital Re Ing Physician: The Is ter this certificate ha meral director, page 2 pa	2	examiner?	Hospital: 1 Mppatient 2 ☐ ER/Outpatien 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	t 3 🗆 DOA Ott	her: 4 Nursing Hon		ce 6 ☐ Other (Spe	city)
WILL OUGH BY, Division of Vital To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page Medical Certification: To Be Co	el micani	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined]Yes 2 □No 2	8f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
o the Hospita ithin 24 hours o the Funeral ompletely fille		29a. Certifier (Check only one) 1 CertifyIng Phy	i ysīclan: To the best of my knowledge, death iner: On the basis of examination and/or inv and manner stated.	occurred at the trestigation, in my	time, date and place, a opinion, death occurre	and due to the car ed at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)
To the within To the comp		29b. Signature and title of certifier	>		se number		d. Date signed (Month	
38		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type, F	Print) 3455	WILFAS	AVENUE !	SUTTE L	
State Registrar		31. Date filed (Month, Day, Year) OCT 2 6 2011	32. Registrar's Signature		-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical acility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of UR **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months JUNE 25 1936 MARYLAND 216-26-7436 Director Yrs 75 Usual Residence of Decedent Show 10a. State er than "natural", or items 23a or 28a-f sho the M-dical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits **BELCAMP** HARFORD 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1212 ASHMEAD SQUARE 21017 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) Coilege (1-4 or 5+) DOMESTIC HOUSEWIFE 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic vonce. CHARLES BENTON FLORENCE DORA BARR LeBRUN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1212 ASHMEAD SQUARE, BELCAMP, MD 21017 PAUL WILHELM, JR./ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State BAYVIEW CREMATORY 10/22/11 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundamental rvice Licensee 22 Name and Address of Earlith INC. TILLY & ZEILER INC. 700 S. CONKLING ST. FUNERAL HOME, BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a cons Exami burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical phys the b as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) page 2 should be detached for Month Pregnant at time of death Day Year Unknown 9 Unknown or Attending Physician; The law requires that the Records, P.D. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 🔀 Natural 5 Pending injury 2 🗌 No Accident Investigation M 24 hours after deal Funeral Director: Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medicap Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier M.D30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yea 6 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 12:58 Α 2011 October 0 Medical Oakley Clarence Willard, 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Timonium <u>Stella Maris</u> If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months 230-16-7149
Usual Residence of Decedent Director 1 🔀 M 2 🗆 F 88 Yrs. 1923 Virginia 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at with the Maryland Director 1 Yes 2x No Maryland Glen Burnie Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral <u> United States</u> 250 Pershing Ave S.W 21061 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1X Yes 2 No Black, White, etc. 1 Never Married 2 Married ğ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give Year or Dates. 1945 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) General Motors Welder Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Victoria (unknown) Oakley Clarence Willard, Sr. 23, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traumones. Glen Burnie, Maryland 21061 250 Pershing Ave, S.W., Brenda Lorince/daughter OCTOBER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mountainview Cemetery 10/29/11 Vinton, Virginia 22. Name and Address of Facility Signature of Funeral Service Licenses Kirkley-Ruddick Funeral Home Md 21061 21 Crain Highway, S.E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a incresiquente of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death Month 5 Other (specify) Pregnant at time of death been signed by the a should be detached 1 Yes 2 L WILLARD Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of OAKLEY 24a. Was an 24 hours after death.

Funeral Director: After this certificate has be Funeral director, page 2.8 performed? death? 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The retriging Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

JACKIE JONES,

26

CRNP

TIMONIUM.

MD 21093

2300 DULANEY VALLEY RD.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8:00 AM Physician/ Oct. 18, 2011 Dorothy P. Warner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 403 W. Ordinance Rd., Apt. 301 Linthicum 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Hours May 8, 1929 1 M 2 X F Michigan 373-28-1604 82 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director be notified 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number Funeral items 23a 21061 403 W. Ordinance Rd., Apt. 301 United States must ! 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 x No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 ₩ Widowed 4 □ Divorced White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, College (1-4 or 5+) Elementary/Seconday (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary Ruth Potter Forrest Lee Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy L. Downie / Daughter 9051 Dunloggin Ct., Ellicott City, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Burial 2 X Cremation 3 - Removal from State October 19 Atlantic Crematory Glen Burnie, Maryland 5 Other (Specify) 22 Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 21. Signs MD 21061 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ O.Mine disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTEN SION 2 No 3 Probably 4 Unknown 1 Yes HYPERZIPIDEMIE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 Yes 2 No Yes 2 X No No ure year, within 24 hours after death.

To the Funeral Director: After this certifica to the Funeral director, the funeral director is the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5\(\begin{array}{cccc} \text{Residence} & 6 \sup \text{Other} \(\text{Other}\) 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Koun October 19, 2011 Kouybruem 12630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rani S. Karipineni, M.D., 202 W. Maple Rd., Linthicum, Maryland 21090 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:45a Dorothy Ann Yankanich 2011 October /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Sykesville Brinton Woods Nursing Center 8. Date of Birth (Month, Day, Nov 10 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🙀 F PA 200-24-3216 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mential Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Silver Spring MD Montgomery 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20906 12422 Flack Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Y Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic housewife 27 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene C. Lilly John F. Bittlebrun ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12422 Flack St., Silver Spring, MD 20906 Andrew Yankanich (spouse) item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10-29-11 New Baltimore, PA St. Johns Cemetery 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Page Haught Sterbert P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not after the mode of dying, such as a reliac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 10 Me **Physician** una disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dus to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) o ate has been signed by the page 2 should be detached 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 HNO 25. Was case referred to medical examiner? director 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ¶o 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the Pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check on one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title

30

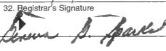
DHMH 17 Rev 1/2001

State Registrar

OCT 2.6.2011

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month gay 2011 8:26 P M Adams, Jr. William K. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot St. Michaels 110 Gloria Ave. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday, 54 Yrs. 8. Date of Birth **Funeral** Hours 213-70-8189 (M8nth 2 4ª 1957 Md. Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov notified at shov 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No St. Michaels Talbot Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a or U.S.A. Funeral 21663 110 Gloria Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White etc. White Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Navy Completed 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.

is marked other than "natur raumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Waterman Be 18. Mother's Name (First, Middle, Maiden Surname)
Virginia Lomax 17. Father's Name (First, Middle, Last) ပ William K. Adams, it. Page 1 and 2 should be triment of Health and Ments rtant: If item 27 is marked njury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) Sarah E. Adams/ Wife 19b_Mailing Address (Street and Number of Rural Route Number, City of Town, State 7in Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition
1 ☐ Burial X Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of crem. of De Imarva 10-13-2011 De. Delmar, 4 ☐ Donation 5 ☐ Other (Specify) Hurbey Ado Ostrowski Funeral Home P.A. 21. Signature of Funeral Service Licensee P.O. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ESOPHAGEDAL CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Exami Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the aid be detached for 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has t director, page 2 s autopsy erforr death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

6+VA State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM

only one)

29b. Signature and title of certifier

8221 TEAL DRIVE, EASTON, MD 21601

29c. License number

D0066409

29d. Date signed (Month, Day, Year)

10-11-2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

		_	For State of Ma	iryland / Depa <i>Cer</i>	artment of Fi tificate of D			ene a. No. 201	31.11.3
	Physicia	n/ al er	Decedent's Name (First, Middle, Last) JACK R. ANGELL			2. Date of Death Month OCTOBER	11, 201 ^{Year}	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		OCTOBER	ER 11, 2011 9:05 A M		
	LAGIIIII		28613 Clubhouse Drive		Easton			Talbot	
	Funeral Director		103-18-7534 ¹ X ^{M 2 □ F}	(In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 1–12–19	9. Birth Cou	nplace (State or Foreign ntry) NY
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Talbot Faston 1XYes 2 □ No						
		Director	MD Talbot 10e. Street and Number	Easton	10f. Zip Code		10	g. Citizen of What Cou	
		Funeral	28613 Clubhouse Drive		21601			USA	
980		by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Every Armed Forces? 1 Yes 2 If Yes, Give	11	Was Decedent of His f Yes, specify Cuba I ☐ Yes 2 🛣 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
2-0		Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupa		ding 1	6b. Kind of Business I	ndustry
121		To Be	Elementary/Seconday (0-12) College (1-4 or 5+) 12 College (1-4 or 5+) Vice President Oil Refinery						ry
pu			17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)						
<u>ya</u>			Robert Angell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Ma			19a. Informant's Name/Relationship (Type, Print) Carolyn Angell (Daughter)	1	ng Address (Street a 18 Corbin		al Route Number, C Caston MD		Code)
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 □ Burial 2 【 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo	sition (Name of	ما	Date 2	0c. Location - City or	
altir			Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Cremation 10-12-2011 Stevensville, MD						
E		iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between						
	Pnysician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Head of the least of the lea						
15	cate be executed physician and the bunal-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
		Examiner	Cause (Disease or iinjury that initiated events c.	consequence of):	nce of):				
0		edical	d						
68760			IF FEMALE:	of programmy					
f Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 12 Unknown 23d. Date of delivery Month Day Year Year Yes 2 No 9 Unknown Year Year Yes 2 No 9 Unknown Year Year Yes 2 Yes 2 Yes 3 Yes 3 Yes 4 Yes 5 Yes 5 Yes 6 Yes 6						•
		þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 toknown						
		Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No						
		To Be	25. Was case referred to medical examiner? 1						
			27. Manner of Death 28a. Date of injur	1 Inpatient 2 ER/Outpatient 3 DCA Versing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 1 Yes 2 No					
		Certificate:	2 Suiside 6 Could not be					Location (Street and Number or Rural Route Number, City or Town, State)	
_		Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	To th withir To th comp	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)						
			MD 0008/132 10-11-11						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JORGE H. ABREGO, MD 598 CYNWOOD DRIVE, STE. 104, EASTON,									601
Ì	Sta Registr		31. Date filed (Month, Day, Year) OCT 12 2011	r's Signature	wer	-			

OCT 12 2011 Rema

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me,923,01/27/2012d Brand Hygiene Certificate of Death Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Roy M. Anderson **Physician** October 201[°]1 10:45 AM /Medical 4a. Facility Name (*If not institution, give street and number)*Anne Arundel Medical Center 4c. County of Death
Anne Arundel 4b. City, Town, or Location of Death **Examiner** Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 28, 5. Social Security Number 212-70-3084 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) XXM 2 D F 54 West Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Maryland Annapolis Anne Arundel Director 1 ☑ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 323 Glen Avenue 21401 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes **XX**No Specify: <u>ک</u> Specify 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 7 is marked other traumatic event, il permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Anderson Jacqueline Melvin ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie Anderson/son 155 Middleton Place Mooresville, NC 28117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 10/11/2011 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se vice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** And in macular disease or condition resulting in death) /Medical Due to (or as a consequence of): CERTIFICATION APPROVED BY INCOCAL EVANIMER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed Usteu and the burial-tran resulting in death) Last Due to (or as a consequence of) Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) ed by the a 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 🗆 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this o funeral 28a. Date of Injury (Month, Day, Year) Unknown 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending Division 1 Matural 5 ☐ Pending investigation Unknown M 1 ☐Yes 2 X No Unknown s after death. death, the 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Unknown 28f. Location (Street and Number or Rural Route Number, Unknown State) filled in by determined 4 Homicide within 24 hours a To the Funeral L the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00057635 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 my Unmalis Words 001

DHMH 17 Rev 1/2001

State

Registrar

im 31. Date filed (Month, Day,

OCT 06 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:10 P M Richard L. Ay, Sr. October 06 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Linthicum Heights Tate Chesapeake Hospice House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year)
June 03, 1930 Months Country) Maryland 1 🔀 M 2 🗆 F 81 213-26-1683 Director Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Severna Park MD 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 600 McKinsey Park Drive, Apt. 206 21146 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 ☐ Never Married 2 🏋 Married Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 - Widowed 4 - Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours posturement of Health and Mental Hygelne. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electric Generator Sales 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Anna Martha Lerian Edward Frederick Ay 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 McKinsey Park Drive, Apt. 206, Severna Park, MD Angela Ay / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State October Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2011 P.A. Severna Park Funeral Home Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart full me. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIO PROSTATE CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit equires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 L 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? performe certificate 1 Yes Hospital or Attending Physician: **Division of Vital** eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Tes Other: SICE ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 \square Pending 1 Natural 2 Accident 1 Tes 2 No after death Investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined To the Hospital
within 24 hours a
To the Funeral C
completed filled Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Box 68760

ddress of person who completed cause of death (Item 23a) (Type, Print) O'KEETE NO

23a) (Type, Print) ZOC 3MEDICAL PARKINY SVIETOU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. FoAMEDN#20A, B, C Per FFS state of Maryland / Department of Health and Mental Hygiene State Registrar 10/7/2011 AACO HEALTH DEPT. CMH Certificate of Death 34146 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 091 2011 HUMAS bel Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 6. Sex If Under 1 Year | If Under 24 Hrs. 8, Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Hours June 28 Year 929 Marvland **Director** 82 214-26-7295 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location notified at Director Mary1and Anne Arundel Annapolis 1 ☐ Yes 2 🌠 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? the Medical Examiner must be with t Funeral items 23a 21403 USA 1175 Madison St. Apt B2 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ö 1 Never Married 2 Kmarried 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural", Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Annapolis (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housing Authority 10th Plumber | and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Irene Parker Thomas J. Abel Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heattn and Department of Heattn and Important: If item 27 is 1175 Madison St. Apt B2 Annapolis, Md.21403 Daisy Abel(Wife) 20b. Place of Disposition (Warne of 20a. Method of Disposition Bal Ciliore, City of Town, State 10/6/2011 cemetery, crematory or other place, +X Burial 2X Cremation 3 Removal from State Crownsville, Md. -9 - 23 - 114 Donation 5 Other (Specify) Maryland Veteran Winner a Recessor Facility Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses any in once. Larry Annapolis, Md. 21401 1922 Forest Dr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death NEY MONIA Physician/ PINATI disease or condition Medical resulting in death) Due to (r as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' this certificate 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medica director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending work 1 Yes 2 No ☐ Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18 2011 30. Name and address of person who pmpleted cause of death (Item 23a) (Type, Print) MYY FENSE Caren 32. Registrar's Signature State Back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patrick Joseph Anastasi 4:45 Рм October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Tate Hospice Home Linthicum 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 1 🛛 M 2 🗆 F Months Days Hours Washington, DC 214-84-3243 Director 48 Ĩ963 May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any jones. 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Maryland Anne Arundel Crofton 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1702 Tarrytown Avenue 21114 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🐰 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Metro HVAC Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Anastasi Helen Ermina Zois 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Anastasi / Wife 1702 Tarrytown Avenue, Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 10/15/2011 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the dis ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the ail id be detached for 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has t autopsy performe certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be director, 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl

To the Funeral Director:,
completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year,

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D 0035413

Stephan Charles Kurylas, M.D., 2191 Defense Highway, Suite 104, Crofton, MD 21114

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Nedra Elaine BURKE 4:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Meritus Medical Center Hagerstown 8. Date of Birth
(Month, Day, Ye
June 16, Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** ^{Year)}19<u>34</u> 1 □ M 2 🏻 F Months Hours 77 Director 220-28-8416 Maryland Usual Residence of Decedent 28a-f shov other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 19800 Tranquility Circle 21742 USA or items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify white "natural", Specify: 3X Widowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 bookkeeper hank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Emmert Franklin Knepper should be Elsie Eudora Ernde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Sandy Cummings - daughter 11030 Roessner Ave., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park 10/17/11 Williamsport, Maryland MINNICH FÜNERAL HOME Signature of Funeral Service Lig 22. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the death certificate be executed and -tran resulting in death) Last physician a sthe burial-t Physician/Medical P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Pregnant at time of death ed by the a a Unknown signed I Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given i<u>n</u> Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 3 Probably 4 Unknown 2 No Completed been 3 iden 24b. Were autopsy findings available 24a. Was an or Attending Physician: The law prior to completion of cause of death? has autopsy page yes 2 No T certificate 1 Yes 2 Ho 25. Was case referred Be 26. Place of Death (Check only one) examiner? Hospital: 2 7 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 Tyes 2 🗌 No the Accident Investigation 24 hours after deat Funeral Director: within 24 hours after des

To the Funeral Director

completed filled in by th 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) To the 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 21740 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Crobe Physician/ 5 oma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 8. Date of Birth 9. Birthplace (State or Foreign Age (In y/s. last birthday) Sex 1 M 2 □ F **Funeral** 8 Months Days Hours (Month, Day, Country) **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 XYes 2 No a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2161 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Kla 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) umberina DOT +h Be 17. Father's Name (First, Middle, Last) ပ nomas van 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Woodval e *blumbia* 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10-14-2011 D over rematory 4 Donation 5 Other (Specify) of Funeral Service Licensee Kace 22. Name and Address of Facility Cambridge, Md 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Sepsi disease or condition resulting in death) Medical Du to (or as a consequence of): Examiner 2th lerosclero to c Vascular disease Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 ☐ Yes ≥ L 9 ☐ Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been s completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Tes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 No မ 1 Yes 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: 1-XNatural (Month, Day, Year) 5 Pending 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 🔾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 10/6 dress of person who completed cause of death (Item 23a) (Type, Print) nd a Cambridge MD 1+2 SOM

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia		Registrar 1. Decedent's Name (First, Middent John Babco, Sr.	,				Cranoc	10 07 2	Joann		2. Date of De Month October		^y 2011	Year	3. Time of Death 12:38 P M
Medic Examin		4a. Facility Name (if not institution Kline Hospice		et and numb	per)			ty, Town, or					. County o	of Death	
Funeral Director		5. Social Security Number 199-30-2841	6. Sex	1 2 🗆 F	7. Age (In yrs.	last birthda 73 Yrs	Month	der 1 Year Days	If Unde Hours	Min.	8. Date of Bir July 2		938	9. Birth Peni	place (State or Foreign nsylvania
aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. Count Maryland Fre	deric		10c. C	ity, Town or	Location	ck						T	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the Ma 23a or 28 ist be noti	eral Dire	10e. Street and Number 7310 Mountaind				10f. Zip Code 21702							tizen of W		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. In the Maryland I show the them Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 Never Married 2 Mar. 3 X Widowed 4 Divorce	12.	Was Deced Armed Ford		n U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)							14. Race - American Indian, Black, White, etc. Specify: White		
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be filed with antal Hygier ked other t c event, th	To Be C	12 17. Father's Name (First, Middle Joseph Babcoe	, Last)			Co	mpute	r Pro		her's Nam	e (First, Middle,				Publication k.)
d 2 should alth and Me 27 is mar r traumati		19a. Informant's Name/Relation John Babco. Jr									al Route Numbe				Code)
Page 1 and ment of Hermant: If item ury or other		20a. Method of Disposition 1 Substitute S		noval from \$	State	Rest1	sposition (A crematory of naven al Gai	r other plac	ce)	Oct. 2	Date 8, 011				own, State Maryland
permit. Departr Imports any inju		21. Signature of Funeral Service	Licensee				resth	and Addre	füne tin	ral S Mount	Service: ain Hwy	s, S y. F	kkot reder	Cod	y P.A. , MD 21701
hysician/		23a. Part 1. Enter the disease, shock, or heart failure. I Immediate Cause (Final disease or condition	only one ca	ause on eac	h line.						or respiratory a	rest,			Approximate Interval Between Onset and Death
Medical Examiner		resulting in death) Sequentially list conditions,	f b												
be executed sician and burial-transit	Examiner	If any, leading to immediate													
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c.	1 Live B	ome of pregr lirth 2 Fe ant at time of own	tal death	3 Ectop 5 Other		су				23d. Date Mon		very Day Year
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The law req	Completed										24a. Was auto perfo 1 \(\sum \) Yes	psy ormed?_	p	rior to co eath?	opsy findings available ompletion of cause of
hysician: nis certific I director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hos	oital: 1 🗌 li	npatient 2 [] ER/Outpa	atient 3 🗆	Oth	or.	-	k only one) ome 5 ☐ Resi	dence	6 ⊠ Othe	(Specif	Hospice W House
eath. or: After th the funera	Certificate:	27. Manner.of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Coul	ding stigation	28a. Date o (Month	f injury n, Day, Year)	28b. Tim inju		28c. Injur work 1 🔲		□No	28d. Describe	how inju	y occurre	d	
vital or Att urs after d ral Direct lled in by		4 Homicide deter	mined	buildin	of Injury - At h g, etc. <i>(Speci</i>	fy)					City or To	wn, State	*)		al Route Number,
Fo the Hosp within 24 ho Fo the Fune	Medical	(Check 2 Medical	Examiner: ng Nurse Pr	On the basis	s of examinati	on and/or in	vestigation, ge, death oc	in my opinie	on, death on time, da	occurred a	nd due to the ca t the time, date ce, and due to th	and place ne cause	e, and due s) and mar	to the ca	ause(s) and manner stated
		30. Name and address of perso	n who comr	eleted cause	of death (Ite	m 23a) (Tvr	e, Print)	2006					06-1	(
Stat	e -	M. M. G. G. C. C. Os 31. Date filed (Month, Day, Year)	tein , al	10	501 h	J 775	57. , 1	-lede	stele	, ND	2170	(
Registra		UCT 1	1 2011	1	gistrar's Sign	A. ,	park								

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

ORIGINAL

32. Registrar's Signature

OCME

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

31. Date filed (Month, Day, Year)

OCT 2 6 2011

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

October 17, 2011

			State	d / Depa	delible Ink. Ensure A artment of Health and N rtificate of Death	Mental Hy	giene	ole.
	Physici	_	Registrar Decedent's Name (First, Middle, Last) Catherine Virginia Barca		Timoate of Death	2. Date of Dea Month	Day	Year 011 3:30 p M
4	/Medio Examir	er	4a. Facility Name (If not institution, give street and number) Heritage Harbour Health & Reha		4b. City, Town, or Location of Death Annapolis If Under 1 Year If Under 24 Hrs.	1	4c. County	of Death nne Arundel
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ 7. Age (In yrs. 90) Usual Residence of Decedent	Yrs.	Months Days Hours Min.	8. Date of Birt (Month, Da Feb. 2	y, Year)	Birthplace (State or Foreign Country) Virginia
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idheal Examiner must be notified at	Director	10a. State 10b. County 10c. Ci MD Anne Arundel 10c. Ci 10e. Street and Number	Annapo			10g. Citizen of V	10d. Inside City Limits 1 □ Yes 2 ▼ No
	eath with is 23a or imust be n	Funeral Dir	2700 South Haven Road 11. Marital Status 12. Was Decedent Ever in U	S 13.	21401		USA	e - American Indian,
980	72 hours after d natural", or iten dical Examiner	र्व	Armed Forces? 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give ↑ Year or Dates:		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Blac Specify	ck, White, etc. White
Maryland 21215-0036	be filed within 72 ho tal Hygiene. d other than "natul event, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation e kind of work done during most of wor DO NOT use retired) L'ESS	king		siness/Industry Service
land 2	2 should be filed and Mental Hygi is marked other aumatic event, tl	To Be Co	17. Father's Name (<i>First, Middle, Last</i>) John Abraham Dyer	1	18. Mother's Nan	ne <i>(First, Middle,</i> E lise S t	. Maiden Surnam erling	ne)
	2 # Z		19a. Informant's Name/Relationship (Type. Print) William D. Rutan / Grandson	4932	ing Address (Street and Number or Ru 2 Lerch Drive Shad	dyside,	MD 20764	4
Baltimore,	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	etro Cr	rematory, INC	ber 6, 2011		City or Town, State
Bal	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	4			Park, M	1D 21146 Approximate
5	Physician /Medical Examiner		23a. Part1. Enter the obease or complications that caused the deal shock, or hand the cause on each line. Immediate Cause (final disease or condition resulting in death) Due to (or as a consecution or complication)	lia c	Amyltonia	c or respiratory a	mest,	Interval Between Onset and Death
	be executed ician and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last					
68760,	ate hys		Due to (or as a consected.	quence or):				
.O. Box	certif Iding Ise as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)			te of delivery onth Day Year
Δ.	w requires that the death been signed by the atter should be detached for L	ed by Pł	Part II. Other significant conditions contributing to death but not re-	sulting in the u	underlying cause given in Part I.		tobacco use cont Yes 2 □ No	tribute to the cause of death? 3 Probably
al Reco	The law ate has b page 2 sl	Completed by				24a. Was auto perfi 1∐ Yes	ormed?	Were autopsy findings availabl prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Division or Vital Records,	or Attending Physician: Thatter death. Director: After this certificate in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1	28b. Time of Injury	ont 3 DOA Other: Nursing Hoof 28c. Injury at Work? M 1 Yes 2 No	28d. Describe	idence 6 □Oth how injury occur	
_	of the Hospital or A thin 24 hours after of the Funeral Direct mpletely filled in by	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my kn (Check only one) Medical Examiner: On the basis of examinand manner stated.				e, date and place,	

State Registrar

29b. Signature and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditya Chopra 600 Ridgely Avenue, Annapolis, MD 21401 31. Date filed (Month, Day, Year) 0CT 07 2011

tle of certifier

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ BROWN 0335 AM Hanes 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville haelestown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 1 □ M 2 💢 Months Hours Min. 873071⁵20 168-16-7895 PA 91 **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director be notified 1 Yes XX No Catonsville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe items 23a Funeral 21228 USA **Examiner must** 715 Maiden Choice Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. th and Mental Hygiene. 27 is marked other than "natural", or i traumatic event, the Medical Examin Completed by 1 Never Married 2 Married 1 Yes 2 XXIo If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XXNo Specify: XX Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Agnes Fleming Alexander Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville, MD 21228 2105 Cedar Circle Drive Scott Brown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State 10/5/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facilit Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pneumonia Physician/ Bilateral disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 \sum Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending 2 No 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R144682 October

Registrar

DHMH 17 Rev 7/2009

State

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gistrar's Signature

atonsville, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Manyland 1761720 Fluid Health and Mental Hygiene 1 = State America 11 Cem 25 per HPGC10-19-11cr Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day10 Month / D Physician/ 10.55 AM rampan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Hospital Montgomer IVEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day, . Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 22380 3961 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 ☐ No Chinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20735 5903 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Iack 3 Divorced 4 Divorced Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired), (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 1-000 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Davis Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Clinton 20c. Location - City or Town Cheltenham, M 20a. Method of Disposition 20b. Place of Disposition (Name of 10-18-2011 1 ■ Burial 2 Cremation 3 Removal from State Chellenkan Veferans Cen 5 Other (Specify) Greene uneral Service Licenses -uncral 22. Name and Address of Facility Sign 22314 14 Franklin St Alexandria 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Sepsis Physician/ e vere disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 00416 FIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Bracent at time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Pregnant Day the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 🗌 Yes 2 🗍 No 3 🗌 Probably 4🔏 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe Director: After this certificate has Yes 2 of Vital or Attending Physician: 25. Was case referred to medical pleted filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 1 X Yes မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Deal Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No death. Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital or within 24 hours aft To the Funeral Dis completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50

Registrar DHMH 17 Rev 7/2009

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32. Recistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ei

Thomas

31. Date filed (Month, Day, Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34155 For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Mary Marie Brinkman 11:50 PM 10 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-Frostburg Nursing & Rehab Center Frostburg Allegany Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country)MD 1 M 2 KF Dec 75 220-10-4929 Director 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21532 48 Tarn Terrace USA ıral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No or i Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give "natural", 3 X Widowed 4 ☐ Divorced Specify white Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) school bus aide School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ William R. Stewart Mary R. Light 19a. Informant's Name/Relationship (Type, Print)
Ruth Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 Cumberland MD 21502 sister Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hillcrest Memorial Park 10/24/20 Cumberland MD tion 5 Other (Specify) Funeral Service 22. Name an Scarpellif Fullieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ Endstas disease or condition month resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner If any, leading to immediate Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 3 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Nomocks 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

DHMH 17 Rev 7/2009

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Bishop

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:49 PM tuinir 0 Medical 4a. Facility Name (If not institution, give street and Location of Death 4b. City, Town 4c. County of Death Examiner HIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/04/1964 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Mir 1 € M 2 □ F Yrs Director Honduras None Usual Residence of Decedent 28a-f shov items 23a or 28a-f shorer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore Owings Mills Md 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with Honduras 21117 8 Sierra Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ō 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 🔀 Yes 2 🗆 No Specify: Honduras "natural", Specify: Hispanic 3 Widowed 4 Divorced traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction 9th Labor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ပ Juan Cuellar Victoria Munguia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Sierra Cir. Owings Mills Md 21117 Dolaura Salinas/Fiance 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 7 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6 Department of Important: If any injury or once. 10/18/11 Honduras General Cemetery Funeral Service Licen e John T. Rhines Funeral home 22. Name and Address of Facility 3005 12th. St. NE Wash. D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between d Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): ing physician a Physician/Medical Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death the 9 Unknown Unknown P.O. by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use combute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes page 2 should 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? performed' certificate | 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 \sum No 26. Place of Death (Check only one) Be Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending To the nosprace within 24 hours after death.

To the Funeral Director: Aft ☐ Acciden Accident Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, completed filled in by 4 \square Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check rtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29c. License numbe 29d. Date signed (Month, Day, Year) 9

Registrar

State

31. Date filed (Month

Day,

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	partment of Health and M	ental Hy	giene
			Registrar Co	ertificate of Death		Reg. No.201 34 57
ı	Physicia Media		Decedent's Name (First, Middle, Last) RICHARD RAYMOND CABANA		2. Date of Dea	ath 3. Time of Death 2:20 P ^M
	Examir	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
24-100	-	•	WRNMMC 5. Social Security Number 6. Sex 7. Age fin vrs. last hirthday	BETHESDA		MONTGOMERY
	Funeral Director		036-22-3993 1 M 2 □ F 75 Yrs.		8. Date of Birt (Month, Day JULY 11	9. Birthplace (State or Foreign Country) PARTODE ISLAND
	ihow at	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Aaryla 8a-f s tiffied	Director	D.C. NONE	JASHINGTON		1 1√2 Yes 2 □ No
	a or 2 be no	<u>=</u>	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	h with	Funeral	3700 NORTH CAPITOL ST. N.W.#310	20011		U.S.A.
	r deat	교	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 □ Never Married 2 □ Married 1 XI Vas 2 □ No 2	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
036	s afte ral", c Exar	ed by	1 Never Married 2 Married 1 Married 3 Widowed 4 Divorced 14 1 Sec. 1975	1 ☐ Yes 2 🕅 No Specify:		Specific
5-0	"natu dical	plete	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation		WHITE 16b. Kind of Business Industry
121	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	e kind of work done during most of working DO NOT use retired)	g	
0 0	ed wil Hygie other ent, th	Be C	12 17. Father's Name (First, Middle, Last)	S. AIRFORCE		DEFENSE
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland di Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke other than "natural" are inequal Examiner must be notified at matic event, the Medical Examiner must be notified at	2	ROLAND CABANA	18. Mother's Name		,
lan	an sh		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural I		
	1 and 2 of Health item 27 other tr			EWEY AVE., PAWTUCKE	ET, RI.	02861
סר	0		1 22	ematory or other place)	- 1	20c. Location - City or Town, State
Baltimore,	permit. Page Department Important: I any injury o once.		04 0	N NAT'L. CEM. 12-5-		ARLINGTON, VA.
Ba	Dep Imp any	12	MM Chambers M00091	2 Name and Address of Facility CHAMBERS FUNERAL HO 5801 CLEVELAND AVE.	, RIVE	RDALE, MD. 20/3/
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arre	est, Approximate Interval Between
- P	h sician/ Medical	ìγ	Immediate Cause (Final disease or condition resulting in death) a. STAGE IV LUNG CAN	ICER		Onset and Death
and .	Examiner		Due to (or as a consequence of):			
		iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	conted	Examiner	Cause (Disease or iinjury that initiated events c.			
	physician and the burial (factor)	dical E	resulting in death) Last Due to (or as a consequence of):			
00/	phys phys	Tedic	d			
/80)	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	75		23d. Date of delivery
Rox	the att	Physician/Me		Ectopic pregnancy Other (specify)		Month Day Year
j	ed by detach	P.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e Did tol	bacco use contribute to the cause of death?
IS, I	n sign	0				es 2 🕅 No 3 🗆 Probably 4 🗀 Unknown
Hecords,	as bee	Completed			24a. Was a	
i de	ate ha	e S			autops perform	med? death?
פַ פּ	certific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check of		
	r this (2	1 Yes 2 XNo Hospital: 1 X Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time o	4		ence 6 Other (Specify)
	ath.	cate	1 XNatural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	28c. Injury at work? M	d. Describe ho	ow injury occurred
VISION	fiter de lirecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		f. Location (Sta City or Town	reet and Number or Rural Route Number,
2	ours a	<u>ख</u> ⊦	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	accurad at the time, date and allow and		
the Ho	within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	≥ L	only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at the	e time date an	d place, and due to the cause(s) and manner stated.
٢	1+1	1	29b. Signature and title of certifler	29c. License number	2	9d. Date signed (Month, Day, Year)
	11.		30 Name and address of pages with the latest and the latest and address of pages with the latest and address of pages with the latest and address of pages with the latest and the latest and address of pages with the latest and	VA 0101248719		OCT 06,2011
		\perp	30. Name and addless of person who completed cause of death (Item 23a) (Type, I SARAH PETTEYS CPT MD WRN	MMC, BETHESDA, MD 2	20889 5	600
	State Registra	~	31. Date filed (Month, Day, Year) OCT 12 2011 Server A. Apar	W.		
			Marine La Colonia			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ CHAPMAN DENNIS 2011 2200 M 10 0 Medical 4a. Facility Name (if not institution, give street and number)
Anne Arundel Medical Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** 288-38-8429 Days (Month, Day, Yea May 30, Hours 67 1944 Director Ohio 1 M 2 F Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Severna Park Anne Arundel Maryland 1 🗌 Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21146 U.S.A. 409 Laurel Drive "natural", or items dical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant I fiem 27 is marked other than "natural", or our to rether traumatic event, the Medical Examinury or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examinury expects. Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. White Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Senior Executive Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) Kathryn Melbourne Father's Name (First, Middle, Last)
Richard Baxter Chapman ပ 19a. Informant's Name/Relationship (Type, Print)
Carolyn Chapman/wife Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11146

11146 409 Laurel Drive Department of Health Important: If item 27 any injury or other troonce. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Keremation 3 Removal from State Baltimore Crematory 10/11/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 4 L Donation.

Sign to Prince Licensee 22. Name and Address of Facility John M. Taylor Funeral Home oad 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UNG disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed cause (Disease or injury and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death the 1 ☐ Yes ∠ ☐ g ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy funeral director, page 2 prior to completion of cause of death? this certificate has performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes ျှ 2/No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? s after death. I Director: After t 28d. Describe how injury occurred Medical Certificate: Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined To the Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner. On the basis of examination and only stated and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

within 2

29b. Signature and title of certifie

Name and address of person who completed cause of death (Item 23a) (Type, Print)

alenta

wo strar's Signature 29c. License number

445 DEFENSE HWY

21438

NNAPOLIS MO 7401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 100003/201v1 Physician/ 4:38 P M Clarke Katharine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth **Funeral** (Month, Day, Year) 11/05/1939 Months Davs Hours Min. 1 M 2x xF 71 Germany Director 217-64-7845 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County at 10a. State 10c. City, Town or Location with the Maryland Director must be notified 1 🗌 Yes 2 🕱 No Heights Prince George's Forest Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ items 23a USA 20745 118 South Huron Drive Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No ŏ δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates White Specify. "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) 12th College (1-4 or 5+) In Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sackreuther Anna Emi1 Walter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 118 South Huron Dr. Forest Heights, MD William Clarke / Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Maryland Vet. Cem. ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland 10/13/2011 ☐ Dopation 5 ☐ Other (Specify) 21. Signa of Funeral Service License Kalas Funeral Home PA 22. Name and Address of Facility George P. 20745 al 6160 Oxon Hill Road Oxon Hill, Maryland that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Part 1. Enter the disease, or complications shock or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine in any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4xx Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No has certificate the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Ninpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined

Division of Vital Records, P.O. Box 68760 within 24 hours after death. To the Funeral Director: At

State

29a. Certifier

29b. Signat

(Check only one

Medical

ne and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

City or Town, State)

of death (Item 23a) (Type, Print)

CLINTON, MA 50.3

aistrar's Sianature

Registrar

completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 Month Mary Catherine Calcamp 2011 18:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Garrett County Mem'l Hospital Oakland Garrett Funeral Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 F Min. 01-26-1940 Hours 71 Country Director 220-34-2178 Usual Residence of Decedent or 28a-f show 10a. State 72 hours after death with the Maryland Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Oakland MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral 99 Holly Lane 21550 USA 11. Marital Status . Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No , or 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White "natural", 3XWidowed 4 □ Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Bausch & Lomb Elementary/Seconday (0-12) College (1-4 or 5+) Eyeglasses Line Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Scott Davis Maude Doll Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Gooding/daughter 24 Left Cherry Fork Montrose, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Accident Cemetery:10/18/2011 Eglon, Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 186 WV 26260 Hinkle Funeral Home Davis. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pitysician CANCER TYPE UNKNOWN, METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident 3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 05 Henry Franklin DELAUNEY Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 321 West Side Avenue Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day une 27 Months Hours Maryland Director 87 1924 220-18-2542 June Usual Residence of Decedent your i 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🔀 Yes 2 🗌 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be I Funeral USA 321 West Side Avenue 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates. 1943-45 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Deputy Chief Elementary/Seconday (0-12) College (1-4 or 5+) 12 City Fire Dept. Arson Investigator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Theodore Franklin DeLauney Miriam Belle Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. DeLauney - Wife 321 West Side Avenue, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Cedar Lawn Mem. Park | 10/18/2011 | Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence or): Exami and -tran Due to (or as a consequence of): physician Physician/Medical certificate be P.O. Box 68760 the attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv death? 2 🗌 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home ** Residence 6 Other (Specify) **Director:** After this din by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

17

State Registrar (Check

29b. Signature and title of certifier

· Kutzevá

3 Certifying Nurse Practioner:

CAN

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Avenue

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Chata	partment of Health and M	ental Hygiene					
			Registra AMEND#23a(a)perMD, 10/12/11; BMW, ModS 6		Reg. No.	2011 34 62				
	Physicia Medic		ROBERT & DIVV	ER	Month Day	7 2811 2118 M				
	Examin	ner	4a. Facility Name (if not institution, give street and number) Summerville Assisted Living	4b. City, Town, or Location of Death	4c. C	ounty of Death Prince George's				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	Birthplace (State or Foreign				
	Director		579-48-7843	With Days Flours Willi.	08/16/1934	Washington, DC				
	yland f show ed at	호	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits				
	or 28a- notifie	Direc	Maryland Prince George's	Bowie 10f. Zip Code	10 011	1 Yes 2 No				
	if filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	3512 Moylan Drive	20715	Tug, Citize	en of What Country? U.S.A.				
	r death	y Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- lican, etc.)	l. Race - American Indian, Black, White, etc.				
21215-0036	rs after rral", o Exam	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🖔 No Specify:	Sp	pecify: White				
15-0	72 hou "natu ledical	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of working	g 16b. Kind	d of Business Industry				
212	within giene. er thar t, the N		College (1-4 or 5+)	tomer Service Rep.		Life Insurance				
and		To Be	17. Father's Name (First, Middle, Last) William H. Divver	18. Mother's Name	(First, Middle, Maiden Sur					
Maryland	2 should be file th and Mental 27 is marked of traumatic eve			ing Address (Street and Number or Rural	Mildred M. Boute Number City or To					
Ž.	- 14		JoAnne Combs - Daughter 1209	Fairfield Estates						
nore	Page 1 and nent of Hea ant: If item ary or other	8		matory or other place)		ation - City or Town, State				
Baltimore,	4 P P P	Ŋ	4 ☐ Donation 5 ☐ Other (Specify) Ft. Linco	oln Cemetery 10/12 2. Name and Address of Facility 4:10	/2011 Bren	twood, Maryland				
m	Depar Impol any ir	(3	Appellanellavnor 1	1800 New Hampshire	Ave., Silve	Funeral Home, Inc. r Spring, MD 20904				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
	h sician/ Medical		disease or condition resulting in death) a. Due to (or as a consequence of).	Chronic Cor	gentin	Julien of				
	Examiner	ē	Se uentially list conditions b.	ATN		Y CAR				
	T T	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury							
	ate be execute hysician and the burial-tr		that initiated events c. Due to (or as a consequence of):							
760		ledical	d							
x 687	res that the death certifics signed by the attending p d be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy	230	d. Date of delivery				
Вох	e deatl the att thed fo	ysici		Other (specify)		Month Day Year				
P.O.	that th ned by e detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?				
rds,	aquires aen sig rould b	ted !			1 Yes 2 🗆	No 3 Probably 4- Unknown				
eco	sician: The law require certificate has been si rector, page 2 should I	Completed			24a. Was an 2 autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?				
al B	ian: Th rtificate stor, pa	Be Co	25. Was case referred to medical examiner?	26. Place of Death (Check of	1 Yes 2 No	1 Yes 2 No				
Į Ķ	Physic this ce al dired	မ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	t	ne 5 Residence 6					
o uc	nding ath. r: After e funer	icate	27. Manner of Death 28a. Date of injury 28b. Time of injury 2	f 28c. Injury at 28 work? M 1 1 Yes 2 No	3d. Describe how injury or	ccurred				
Division of Vital Records,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	8f. Location (Street and N City or Town, State)	lumber or Rural Route Number,				
آ آ	In the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and	due to the cause(s) and m	nanner as stated.				
:	To the Hospita Within 24 hours To the Funeral completed filler	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/or inve- only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at the	he time, date and place, an	nd due to the cause(s) and manner stated.				
	Sol with		29b. Signature and title of certifier	29c. License number	29d Date s	signed (Month, Day, Year)				
)		30. Name and address of persoli who completed cause of death (Item 23a) (Type,	Print	1 00	Johan 102011				
	Class		MICFIARZ J. LARENT WY 44 31. Date filed (Month, Day, Year) 32. Registrar's Signature	r Defenset by 1	MNAPOLO	(S M 8) 2140)				
	Stat Registra		OCT 12 2011	Kel.						

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	(First, Middle, L		/laryland		artment of I tificate of L			Reg. No. 2	011	34163
Physicia Medic		Mary I	Evelyn I)ePue					Sept 18	3,2011	Year	6:25am м
Examin	er	4a. Facility Name <i>(if n</i> Potomac		ve street and number) Nursing H			4b. City, Town, o	r Location of Deat Llle	n		nty of Death	ry
Funeral Director		5. Social Security Nur 245-38-26	6. 519	Sex 1 □ M 2 X F	ge (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h 20°;1930	9. Birthp	olace (State or Foreign GY) Carolina
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 23s or 28sa-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	MD	10b. County Anne Ar	undel	1	, Town or Lo					1	0d. Inside City Limits 1 Yes 2 □ No
ath with the	Funeral D	10e. Street and Numb 4709 Was 11. Marital Status		Ave	t Ever in U.S.	13.1	10f. Zip Code 20764 Was Decedent of H		necify Yes or No-		of What Countered State ace - Americ	tes
urs after de ural", or ite al Examiner	by	1 Never Marrie 3 Widowed 4	Divorced	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	No		f Yes, specify Cuba 1 ☐ Yes 2 💢 No	an, Mexican, Puert	o Rican, etc.)		lack, White,	etc.
vithin 72 hou iene. r than "nat the Medica	Completed	(Speci Elementary/Secon		Education grade completed) College (1-4 or	r5+)	(Give life. D	dent's Usual Occup kind of work done o O NOT use retired) inistrat i	duning most of wor		16b. Kind of	Business Ind	dustry
filed w tal Hygi d other event, I	To Be	17. Father's Name (Fi	rst, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Suma	me)	
d Men marke matic	ř	Paul Tu		Time Drint				-	Alma Lo		0: : 7: : 6	N- 453
d 2 sho alth an n 27 is i er traun		Dianne Ku		,			ng Address (S <i>treet</i> 9 Washing					
Page 1 an nent of He ant: If iten ıry or oth		20a. Method of Dispo 1 ☐ Burial 2 ☐ 4 ☐ Donation	Cremation 3	☐ Removal from State	te Ce	emetery, crer	sition (Name of natory or other place Heaven	i	Date 2011		n - City or To	ing, MD
permit. Departr Importa any inju		21. Signature of Fune	eral Service Lice	nge		22	2. Name and Addre	ss of Facility Jo	seph Gav	vler's	Sons,	INC
		23a. Part 1/ Enter the shock, or heart Immediate Cause (Fi	failure. List only	mplications that cause one cause on each li	ne.	. Do not ente					igton j	Approximate Interval Between Onset and Death
hysician/ Medical Examiner		disease or condition resulting in death)		a. Due to (or a	s a conseque	ence of):	la				_	years
	Examiner	Sequentially list cond if any, leading to immo cause. Enter Underly	nediate ving	b. Due to (or a	s a conseque	ence of):						
be executed sician and burial-transit	g	Cause (Disease or iir that initiated events resulting in death) La			s a conseque	ence of):						
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for the pospital or Arenoung Priysician: The law requires that the death certificate within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the least the law of the	Physician/Medio	23b. Was decedent p in the past 12 m 1 Yes 2 9 9 Unknown	onths?	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Fetal at time of de	death 3	Ectopic pregnand Other (specify)	су			Date of delive	ery D <i>a</i> y Year
luires mat ur in signed by uld be detad	by	Part II. Other signific	eant conditions	contributing to death	y t (C	ulting in the L		ven in Part I.	23e. Did to			ne cause of death?
The law recate has bee page 2 sho	Completed	Drabe	les	nelli	ms	tyr	ej		24a. Was autop perfo 1 Yes			psy findings available mpletion of cause of
certific rector,	Be	25. Was case referred examiner? 1 Yes 2		Hospital:		·	Oth	ace of Death (Che				
ding Physith. After this funeral di	cate: To	27, Manner of Death 1 Natural 2 Accident	5 Pending	28a. Date of in (Month, D	jury	ER/Outpatier 28b. Time of injury	28c. Injur	4 X Nursing F y at	dome 5 Residence)
al or Atter s after des al Director ed in by the	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Place of Ir	njury - At hor atc. (Specify)		eet, factory, office		28f. Location (S City or Tow		nber or Rural	Route Number,
ne nospit in 24 hour he Funera ipleted fille	Medical	(Check	Medical Exar	ysician: To the best on miner: On the basis of urse Practioner: To the	examination	and/or inves	tigation, in my opini	on, death occurred	at the time, date a	nd place, and	due to the ca	use(s) and m <i>a</i> nner stated.
10 so the contract of the cont		29b. Signature and tit	tle of certifier	dur	ette	MI	29c. Licens	8 26 2		29d. Date sign	ned (Month,	Day, Year)
, -		30. Name and addres	ss of person who	completed cause of		23a) (Type, F	Print) Lesear	th BL	UD Su	ete 3	Rock 30	20850
Stat Registra		31. Date filed (Month, OCT		32. Regist	trar's Signatu	park	(d)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kenneth OCTOBER 8 2011 7:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death 11087 KITTY'S CORNER ROAD **CORDOVA** TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country)
MARYLAND 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min 91 10/4/1920 Director 217-16-9610 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No TALBOT **CORDOVA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11087 KITTY'S CORNER ROAD 21625 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates WHITE "natural", Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) REGISTER OF WILLS STATE OF MARYLAND permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygiel Important: If item 27 is marked other 1 any injury or other traumatic event, the 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ W. EARL DULIN ELSIE BARCUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELSIE M. RHODES, DAUGHTER 13573 NEWTOWN ROAD, QUEEN ANNE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, EASTON, MARYLAND WOODLAWN MEMORIAL PARK 10/14/2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Li Fela Con.

Pregnant at time of death in the past 12 months? Month been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4-Dunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has birector, page 2 sl autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 Tes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending Accident Investigation Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tisker 225

State

Registrar

10

2 Martin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MISCHUI

12

Ma Hour

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Francis Emory Dill 6 2011 October 4:30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Talbot Genesis Health Care-The Pines Easton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 ☑ M 2 ☐ F Hours 212-56-1072 05 6 4 1950 61 Maryland Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified Trappe 1 Yes 2 No Talbot Md. 6 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4759 USA White Marsh Road 21673 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. o, ģ 1 Never Married 2 Married Francis Dill Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Black "natural" Completed Year or Dates marked other than "natur matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Verizon Office Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ pe Elsie Potts Roy F. Dill 1 and 2 should the Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dill Nascar Ln., Magnolia, De. 19962 Brenda 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State . Page 1 Important: If it any injury or o once. Department of 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Paradise 10-12-11 Trappe, Maryland Cem. 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover St., Easton, Md. 21601 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death SEVERÉ Physician/ FAILURE Medical Examiner DYSPHA GIA E squartlany not be difficulty, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner ARTERY ISCHEMIC STROKE burial-transit CEREBRAL that initiated events resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 No eral Director; After this certific filled in by the funeral director, Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funel completed fil (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Beinet TUS and address of person who completed cause of death (Item 23a) (Type, Print) 3 Lane 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certif	icate of L	Death		F	leg. No.) 3410		
Physicia ledical Examir	ın/	1. Decedent's Name (First, Middle,Last) Levi Joshua		Drive			2. Date of Dea Month October	Day Year 19, 2011	1954 nrs		
)		4a. Facility Name (if not institution, give street and number Western Maryland Health System			. City, Town, o Cumberlan	d		Allegany			
Funeral Director		5. Social Security Number 6. Sex 7. As N / A 1 M 2 F Usual Residence of Decedent	ge (In yrs. łast I	birthday) Yrs.	Months Day		Min	/2011	9. Birthplace (State or Foreign Maryland Country)		
aryland 8a-f show any at once.	tor	10a. State 10b. County PA Bedford 10e. Street and Number	1 "	wn or Location			1.	0g. Citizen of Wha	10d. Inside City Limits 1 Yes 2 No		
h the Mar 23a or 28a	Il Director	1701 Flintstone Creek Ro				155	35		USA		
ine in	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:	? ! 💢 No	If Yes	yes 2 No specify:			White,	White		
15-1)036 filed within 72 hour Hygiene do dother than "natu	mpleted	15. Decedent's Education (Specify only highest grade cor Elementary/Secondary (0-12) College (1-4 or		during mos	t of working life	e. DO NOT	use retired)	16b. Kind of Bus None	•		
21215-(1036 and be filed within 72 Mental Hygiene marked other than over the ment, the Medical	Be Co	17. Father's Name (First, Middle, Last) Jesse Austin		onahue		Sama	s Name (First, Middle, antha	Rachel	Driver		
re, MD 21215 I and 2 should be file Health and Mental H fitem 27 is marked of fitem 27 is marked of	٢	19a. Informant's Name/Relationship (Type, Print) Michael A. Driver / Grandfa 20a. Method of Disposition	ather	1701		tone (ber or Rural Route Nu Creek Rd,	Clearvill	Le, PA 15535		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		Method of Disposition Method of Dis	tate crem	natory or other		,,	Date 10/22/2011		city or Town, State		
_ =====		21. Signature of Funeral Service Licensee		404		ur Sti	reet, Cumb	erland, M			
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a cons	ted her					est, shock, or hear	rt Approximate Interval Between Onset and Death		
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ecuted and and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	equence of):								
'60, rate be executed physician and he burial - transi	Medical	X UNPENDED . AMENDED 23a			22 12-8	8-11 s	Sm				
30x 687 death certific re attending p	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part							23d. Date of d Month	delivery Day Year		
ires that the signed by ill be detached	ã	Part II. Other significant conditions contributing to deat	h but not result	ting in the und	erlying cause (given in Par			oute to the cause of death? Probably 4 Unknown		
cords law requi	Completed						24a. Was autop perfo	pri rm <u>ed</u> ? de	fere autopsy findings available for to completion of cause of eath? Yes 2 No		
tal Rec	Be	25. Was case referred to medical examiner?				Othor -	Check only one)				
on of Vi	tion: To	1 ✓ Yes 2 No Impate 27. Manner of Death 1 Natural 5 Pending Pending	ent 2 ✔ ERA	b. Time of Inju	ry 28c. Inju	ry at Work?		Residence 6 how injury occurred	Other:		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	ıjury - At home,	, farm, street,	factory, office b	ouilding, etc	28f. Location (or Town, §		r or Rural Route Number, City		
To the Hosp within 24 ho To the Fune completely fi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.									
	Ž	29b. Signature and title of certifier			29c. Licens O.C.			29d. Date signed October 20,	d (Month, Day, Year) 2011		
		30. Name and address of person who completed cause of c Ling Li, MD Assistant Medical Examine			Street, Balt	timore, M	MD 21223				
Sta Registr		31. Date filed (Month, Day, Year) 32. Registra	r's Signature								
DHMH 17 Rev 1/200		OCT 2 6 2011 Lenson B.	14 will	RIGINAL				-			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of N	Maryland /				nd Mental Hy	giene			
	_		Registrar 1. Decedent's Name (First, Middle, Last)		Certific	ate of D	eatri	2. Date of De	Reg. No. 2) 	34167	
П	Physicia			OSKI				Month OCTOBER	Day	Year 2011	2245 M	
in.	Medic Examir		4a. Facility Name (if not institution, give street and number,		4b. 0	City, Town, or I	Location of	4c. County		-2-15		
and the same			MEMORIAL HOSPITAL AT E	ASTON		EASTO	N		TAI	LBOT		
	Funeral Director			Age (In yrs. last bi	Yrs. If U	nder 1 Year ths Days	If Under 24 Hours	th ay, 1 964	9. Birthpla Country	ace (State or Foreign N.J.		
	nd how at] <u>-</u>	Usual Residence of Decedent 10a. State 10b. County	10c. City. To:	wn or Location					100	d. Inside City Limits	
	farylar 3a-f s ified	Director	Md. Talbot		St. Mi	chaels				1.00	1 ☐ Yes 2X No	
	with the N 23a or 29 ist be no		10e. Street and Number 23869 New Land Drive			Zip Code 216	63		10g. Citizen of V	What Country	y?	
9200	within 72 hours after death with the Maryland jiene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ted by Funeral	11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Yes 3 ☐	X _{No}	If Yes, s		, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	Blac	14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036	within 72 ho /giene. ner than "nai ner the Medica t, the Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 2)		life. DO NOT	work done du	tion <i>iring m</i> ost o	f working	16b. Kind of B		aration	
Maryland 2	filed val Hyg	To Be	17. Father's Name (First, Middle, Last) Augustas Dabro	ski				s Name <i>(First, Middl</i> e, inifred	Maiden Surname Collins	э)		
	of Health and Ment of Health and Ment fitem 27 is marker rother traumatic		19a. Informant's Name/Relationship (Type, Print) Mary Dabroski/ Sister					or Rural Route Numbe			de)	
Baltimore,	Page 1 an nent of He ant: If iterr ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	- cemet	of Disposition (tery, crematory tory of	or other place	rva 1	Date 0-12-2011	20c. Location -	,	n, State	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	6.5.0				ski Funera . Michaels				
~	Physician/		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition	rest,	lr O	Approximate nterval Between Dnset and Death						
	Medical Examiner		Sequentially list conditions. Due to (or as	s a consequence	e of): YOCAR		LEST INF	ARCTION			lours	
	executed an and rial-transit	Examiner	if any, Leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	s a consequence	ARTER	ey A	THE	ROSCLERO	รเร	Y	EARS	
09	ate be executed physician and the burial-transit	dical	resulting in death) Last Due to (or as	s a consequence	e of):	· 						
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death. Within E4 hours after death. To the teneral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the buse the buse that the properties of the properties			n 2 🗌 Fetal dea at time of death						ate of delivery	/ day Year	
ls, P.O.	uires that the signed by all be deta		Part II. Other significant conditions contributing to death MORBID OBESITY	but not resulting	g in the underlyi	ng cause give	n in Part I.	23e. Did to	obacco use contr	_	cause of death?	
Division of Vital Records,	Physician: The law require this certificate has been si al director, page 2 should	Completed by	DIABETES MELLITUS					24a. Was autoj perfo	psy prmed2	prior to comp death?	y findings available pletion of cause of	
alF	ian: T rtifica ctor, p		25. Was case referred to medical examiner?			26. Plac	ce of Death	(Check only one)	2 KN0	1 Yes 2	L No	
ΖĘ	hysic his ce I direc	은	1 ☐ Yes 2 No Hospital:	atient 2 ER/C	Outpatient 3	DOA Other	4 🗆 Nurs	ing Home 5 Resid	dence 6 🗆 Othe	er (Specify)		
on of	I or Attending Ph after death. Director: After th I in by the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of in (Month, D		. Time of injury	28c. Injury a work? 1 \(\supers	at es 2□N		now injury occurre	ed		
Divisi	ital or Att ins after d al Directi led in by t			njury - At home, f etc. <i>(Specify)</i>	farm, street, fac	tory, office		28f. Location (S City or Tou	Street and Number vn, State)	er or Rural Ro	oute Number,	
	To the Hospital or within 24 hours aft. To the Funeral Dir completed filled in	Medical	29a. Certifier (Check conly one) 1 ★ Certifying Physician: To the bast of the deck only one) 2 ★ Medical Examiner: On the basis of the deck only one) 3 ★ Certifying Nurse Practioner: To the	examination and/	/or investigation,	, in my opinion	, death occu	irred at the time, date a	and place, and due	e to the cause	e(s) and manner stated. ed.	
	To vitil		29b. Signature and fitte of certifier)		29c. License r	number 7112	$_{arphi}$	29d. Date signed			
	ing.		30. Name and address of person who completed cause of	death (Item 23a)		000	/ 1 (2	8	OCTOBER_	_ 67	2017	
	2		ALEXANDER WIELAARD	, 219	S. WASH	INGTON	STRE	ET EAS	TON, MI	D 21	601	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Pegist 0CT 1 2 2011 32.	trar's Signature	box				•			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6, Day 2011 Year V. DeIuliis 8:45 а.м Anthony Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick 7099 Autumn Leaf Lane Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day May 26, Months Davs Hours 174-22-7530 83 Director 1 🌠 M 2 🗆 F Pennsylvania Usual Residence of Decedent show 10b. County ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 7099 Autumn Leaf Lane 21702 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government 12 Plant Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Gennaro De Iuliis Marie Bonetto 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7099 Autumn Leaf Lane, Frederick, Maryland 21702 Concetta DeIuliis wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🙀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Frederick, Maryland Stauffer crematory 10-8-2011 22. Name and Address of Facility Stauffer Funeral Home Sign ture of Funeral Service Licensee 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ me tostotic disease or condition prostate cancer. Medical resulting in death) Due to (or as Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence on: -transit resulting in death) Last Due to (or as a consequence of): attending physician a Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death signed by the at d be detached f Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Diabetes 24b. Were autopsy findings available 24a, Was an portension To the Hospital or Attending Physician; The law page 2 autopsy prior to completion of cause of death? certificate 1 🗌 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Funeral Director: After this stely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 Yes 2 No 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

within 2 To the I

only one

Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

Registrar DHMH 17 Rev 06-2011 65

egistrar's Signature

D 57643

29d. Date signed (Month, Day, Year)

10.7.11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTTOBER 3,2011 Physician/ E DUDDERAR KILY 8:55P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏲 F Months Days Hours 0271471927 WV Yrs. 226-36-4202 84 **Director** Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f shov 10b. County with the Maryland 10a. State 10c. City, Town or Location Director traumatic event, the Medical Examiner must be notified 1 🗆 Yes 2 🏲 No MD Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21788 231 E. Church Street, Apt. "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Midowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 8 cook restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dewey Roberts Florence Rigsby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon Dudderar/daughter 316 Main St., New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/09/2011 Frederick, MD Stauffer Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ardio rulus rary disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Artem Due to (or as a consequence of): and -tran that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical Pailure P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of deliven 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Year Month Day 5 Other (specify) Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 1 Yes 2 No Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 Q Mo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number D 00 69065 _ MD. son who completed cause of death (Item 23a) (Type, Print) 32.1 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O 7:30 pm Physician/ 2011 DauGHERT Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 8. Date of Birth (Month, Day, 12-27 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** M 2 □ F Days Director Usual Residence of Decedent 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5-A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WhITE If Yes, Give "natural", 3 Divorced 4 Divorced Completed Year or Dates. other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72... h and Mental Hygiene. **7 is marked other than "r** Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 6 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, MAHERTY Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-21-11 DENTON DAUGHERTY FUNERAL Sign of re of 5 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. Part 1. Enter the disc shock, or heart failere. e, or complication Onset and Death Immediate Cause (Final Physician disease or condition Due to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last page 2 should be detached for use as the burial-transit and Due to (or as a consequence of): signed by the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 2 Ng 1 Yes 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes 2 WNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Sesidence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2011 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person. wrott DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature anto

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:05am EDMUND ELLSWORTH DeFELICE ober Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ned harle ente Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F (Month, Day Months Days Hours Min 578-82-1655 49 **Director** 196 Usual Residence of Decedent 28a-f sho 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES WALDORF 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 13 BLACKPOOL CIRCLE 20602 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industr (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNITED STATÉS is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Hygiene the TECHNICIAN POSTAL SERVICE 12 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည PASQUALE DeFELICE GLYDON ANN MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once. VICKI DeFELICE-SPOUSE BLACKPOOL CR. WALDORF, MD. 20602 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 D Other (Specify) METROPOLI CREMATORY 10-22-11 21. Signature of Funeral Service Licenses M00479 22. Name and Address of Facilit RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause or each line Immediate Cause (Final disease or condition Physician/ cumpnay Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No detached for Month Pregnant at time of death Dav Year 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 No 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 은 Other: 2 No 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) Olh

State Registrar Leavine

31. Date filed (Month, Day, OCT 26 20

ompleted cause of death (Item 23a) (Type, Print)

LOMPSON

32, Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 ^{Year} 2011 5:12 William Ouincy Fletcher Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) VA If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 08/13/1960 Days Min. 1**X** M 2 □ F Director Yrs. 225-04-9427 51 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 🗌 Yes 2 🗷 No Onancock VA Accomack 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be with 23a Funeral 18535 Dogwood Dr., 23417 USA items ? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. 1 ☐ Yes 2 🗷 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled N/a 12 Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William D. Northam Katherine Fletcher traumatic and 2 should by Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Fletcher / Wife PO Box 317, Onancock, VA 23417 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 X Burial 2 Cremation 3, ☐ Removal from State Foundation Of Faith Cemetery 10/16/2011 Belle Haven, VA 4 Donation 5 Other (S) Signature of Funeral 22. Name and Address of Facility Cooper & Humbles Funeral Co., Inc., Accomac, VA 23301 Part 1. Enter the disease, or compli shock, or heart failure. List only one plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Retween Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) **Examiner** Soquer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): and Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Yes 2 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 1 🗌 Yes 2 🗌 No Hospital or Attending Physician: ' 24 hours after death. Funeral Director: After this certific Vital 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? þ Hospital 2 **X** No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 🗌 No Investigation
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 Name area address of (Type, Print) BA2 State Registrar

DOD: 10/10/11

8/13/100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I tem 9 per FH G921 11/16/11 dk State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct 10,2011 12:10a M S. Sylvia Florsheim Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carriage Hill-Bethesda Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth 6. Sex **Funeral** Age (In yrs. last birthday) (Month, Day, Year) ov 23, 1912 1 □ M 2 🛣 Months Days Hours Washington DC Nov Director 578-12-7693 98 Usual Residence of Deceden 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 23a or 28a-f shoirry or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director MDMontgomery Rockville 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 6145 Tuckerman Lane 20852 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life, DO NOT use retired) Homemaker (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **HOme** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alma Prince Sidney W. Straus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6145 Tuckerman Lane Bethesda, MD 20852 Nancy G. Simon/Daughter 6145 Tuckerman Lane 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 10-13-2011 Falls Church, VA National Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC uneral Sen 5130 Wisconsin Ave, N.W. Washington DC 20016 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Gastric Adenocarcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year as been signed by the 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Parkinson's Disease, Chronic Lymphocytic Leukemia 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? funeral director, page 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🖾 No Other: 유 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After injury 5 Pending fter death. 1 Yes 2 No Investigation the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled n by determined City or Town, State) within 24 hours

To the Funeral Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title certific 29c. License number 29d. Date signed (Month, Day, Year) Oct 11,2011 D2145 10 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 10215 Fernwood Rd, Bethesda, MD 20817 Lee R. Pennington, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park 1 2 2011 OCT Registrar

Amend 10e,#3 p				r Print in I					-		_	e.	
	•	For State Registrar	State	of Marylan		tificate of		and ivi	ientai Hy	/gien Reg. N	201	1 3417	L
Physicia	n/	1. Decedent's Name (First, Middle, Las	,						2. Date of De	eath	ay Year	3. Time of Death	
Medic	al	Dorothy 4a. Facility Name (if not institution, give				4b. City, Town,		45	10	C	6 2011	11:30 pm _M	_
Examin	er		Holy Cross Hospital					of Death			c. County of De		
Funeral		5. Social Security Number 6. Se	ЭХ	7. Age (In yrs. Ia	ast birthday)	Silver Sr If Under 1 Year Months Days	r If Under	24 Hrs.	8. Date of Birth 9. E			irthplace (State or Foreign country)	
Director		255-03-2623 Usual Residence of Decedent	□ M 2 XX F	92	Yrs.					191	_	Alabama	
land show dat	tor	10a. State 10b. County		10c. City	y, Town or Loc	ation						10d. Inside City Limits	
Mary 28a-f	Director	Md Prince G	orges		Greenbelt							1 ∏Xyes 2 ☐ No	
with the	eral	10e. Street and Number 1 FastWay Unit D	1 Eastw	æv Unit. D)	10f. Zip Code 20770				-	Citizen of What C USA	Country?	
death vitems	Funeral	11. Marital Status		edent Ever in U.S		Vas Decedent of I	Hispanic Ori	gin? (Spec	cify Yes or No-		14. Race - Am		_
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. 1 min 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	1 Yes If Yes, Giv Year or D	2 🔀 No ve		☐ Yes n x Ne			nicali, etc.)		Black, Wh Specify: Wh		
5-00 ! hours 'natur dical li	olete	15. Decedent's Ed (Specify only highest gra	ducation		16a. Deced	ent's Usual Occu	pation	a mé um diim		16b.	Kind of Busines	s/Industry	_
Baltimore, Maryland 21215-0036 semit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", on any injury or other traumatic event, the Medical Exampnee.	Completed	Elementary/Secondary (0-12)	College (1		life. DC	ind of work done NOT use retired	1)	t or workin	ig	Corr	oww.ent		
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ylar ild be i Menta narked	욘	Floyd Jackson Stric	klin				Mary	y Mag	gie Ver	mon			
Mar 2 shou th and 27 is m		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailine 1. East	g Address (Street Way Unit I Way Unit	t and Numbe	er or Rural	Route Number	er, City o	or Town, State, 2	Zip Code)	
re, I t and t f Healt ftem 2 other		Mary Bitter 20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of			t, Md 20 Date		Location - City of		
Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications)	Removal from	State At 1	emetery, crem Lantic Ci	natory or other pla rematory		10-10			n Burnie,		
Baltimory permit. Page 1: Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licens				Name and Addre	ess of Facilit	y Fle	ck Funer	al H	ome		
	\dashv	23a. Part 1. Enter the disease, or comp		20054	70	O1 Sandy S		Rd. La	urel, M			Approximate	d
~Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on ea	ach line.					,			Interval Between Onset and Death	
Medical Examiner		disease or condition resulting in death)	Due to	e Bowel (or as a consequ	ience of):		CUION						-
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Box death he atter	Physician/Medical	in the past 12 months? 1 Yes 2 No		Birth 2 Fetal gnant at time of de nown	eath 5	Other (specify) _	icy				Month	Day Year	
P.O. that the uned by the detach	Ę.	9 Unknown Part II. Other significant conditions co			ulting in the ur	iderlying cause g	iven in Part !	1.	23e. Did t	obacco	use contribute t	to the cause of death?	_
S, F Luires the signer and be-	Completed by	End Stage COPD							1 🗆	Yes 2	2 X No 3 □	Probably 4 🗆 Unknown	
Sorc aw requas been 2 shou	plet	Hypertension							24a. Was auto		24b. Were a	utopsy findings available completion of cause of	_
Rec The la	Com	=							perfo	ormed?	death?	es 2 No	
ital sician: certific irector,	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No	Hospital: Y				Place of Deat						
of V g Phys er this neral di	e: 10	27. Manner of Death	Zoa. Date	Inpatient 2 E	280. Time of	{28c. Injui	4 ∐ Nu ryat		ne 5 Resi 8d. Describe l		6 Other (Spe	ecify)	_
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lospita t hours uneral	Medical	29a. Certifier 1 Certifying Phys	ician: To the b	pest of my knowle	edge, death or	courred at the tim	ne, date and	place, and	d due to the c	ause(s)	and manner as	stated. e cause(s) and manner state	×1
the H thin 24 the F		only one) 3 Certifying Nursi					the time, dat			the caus	e(s) and manner	as stated.	u.
P W P 00		1	mani.	ch RSW	111		0654	105			ate signed (Mon	(1) Day, rear)	
	ŀ	30. Name and address of person who co	mpleted caus	se of death (Item :	23a) (Type, Pri	int)						0011	\dashv
CAHIO		Barbara Supanich, 31. Date filed (Month, Day, Year)					ilver	Spri	ng, MD	20	910		4
State Registra		OCT 11 20	11 32.	gistrar's Signatu	B. 4	arked							

Physician Blanche Ida Frady September 30, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FutureCare Chesapeake Arnold If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 □XF 76 216-30-4195 Director May 09, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified Director MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 201 Rushley Road 21012 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Yes. Give Specify. Be Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Manager 12 -, warylanc,
-, warylanc,
permit. Pages 1 and 2 should be file.
Department of Health and Merrillingortant: If item 27 any Injury. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ John W. Magill Mabel Dickson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger M. Frady / Husband 201 Rushley Road Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date October 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2011 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Ritchie Hwy. Severna Park, MD 21146 23a. Part 1. Ent 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feit the list only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a consequence of)

1. Decedent's Name (First, Middle, Last)

Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and

P.O. Box 68760,

Division of Vital Records,

Physician/Medical Completed Be Certification: To s after death.

Sequentially list conditions, if any, reading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗡 Unknown 24a. Was an autopsy performed 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Leath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 በ Certificate of Death

Reg. No.

Day

1935

Year

Anne Arundel

Maryland

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Archbishop Spalding

20c. Location - City or Town, State

23d. Date of delivery

1 □ Yes

29d. Date signed (Month, Day, Year)

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

No

2011

Year

Baltimore, MD

White

USA

Specify.

16b. Kind of Business/Industry

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

unon

1 ∐Yes 2 X No

4:45 P M

2. Date of Death

Month

within 24 hours a Medical State Registrar

address of person who completed cause of death (Item 23a) (Type, Print) ANNAFOLIS COLONY TIDENATUR 32. Régistrar's Signature

29c. License number

31. Date filed (Month

MO

29b. Signature and title of certifie

29a. Certifie

(Check only one)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mønth, **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 73 Yrs. If Under 1 Year | If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, Year) 1 X M 2 □ F 219-26-4177 June 28,1938 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel 1 ☐ Yes 2 X No Director Arnold 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 754 Pine Trail 21012 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 195 1 ∑Yes 2 ☐ No If Yes, Give 195 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1954 Black White etc. 1 Never Married 2 Married 1956 1 ☐ Yes 2 XNo þ White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Beverage Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salvatore S. Franco Lois Cannox ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Marbury/Son-in-law 784 Canvasback Court Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial October Glen Burnie, MD Park 2011 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) preumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No. 24a. Was an autopsy performed? Be မ Certification:

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

I physician and as the burial-tran attending detached f signed b the Hospital or Attending Physician; the 24 hours a Funeral D within 24 hor To the Funer completely fi

Funeral

Director

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must be notified 28a-f

'natural", or items 23a

Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23.

traumatic event, the Medical

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai

Physician

//Medical

Examiner

Baltimore, Maryland 21215-0036

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	as case referred to r	medical		26. Place of Death (Check only one)									
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1 2	Accident	Pending investigation	(Month, Day Year)	8b. Time of Injury M	28c. Inj W 1 (rk?	2 🗌 No	28d. Describe	how injury				
-	☐ Suicide 6 ☐ ☐ Homicide	Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, facto	ctory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated.									use(s)				
29b.	Signature and title of	f certifier		2	9c. Licer	se nur	mber		29d. Date	signed (Month, Day, Year	r)		

RES-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Ortober 5, 2011

State Registra

Medical

Tillary

31. Date filed (Month, Day, Year,

M. Freder

32. Registrar's Signature

parked

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GARFIELD 2011 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Cheverly Prince Georges Hospital Center . Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 Months Days Hours 578-14-0724 96 March 18,1915 **Director** Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** be notified District of Columbia Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20019 5200 East Capitol Street, N. E. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black 3XXWidowed 4 ☐ Divorced Year or Dates Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5th grade Custodian Space Cleaners Ith and Mental Hygien 27 is marked other the r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Mary Alice Martin Tinsley Freeman 19a. Informant's Name/Relationship (Type, Print (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5200 East Capitol Street, N.E.; Washington, D.C. 20019 item 2 other 1 Geraldine Lorraine Lee Clay 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Oct. 26,2011 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Maryland National Memorial Park Laurel, P.G.Co.Maryland 21. Signature of Funeral Service Li 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Enter the disease Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Exami Cause (Disease or iinjury that initiated events resulting in death) Last and as the burial-tran Due to (or as a consequence of): the attending physician To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy signed by the atte in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, Completed 1 🗌 Yes 2 🗹 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 No 1 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) မ 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 \square Pending injury Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-01-2011 death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Grimm Myrtle Margaret 2011 7:20 A October Medical 4c. County of Death Washington 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Boonsboro Reeders Memorial Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Days Hours AUG. 15, 1922 Mary Tand 188-12-3582 89 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Washington Boonsboro XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 141 S. Main Street 21713 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: If Yes, Give White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 8 Housewife Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma Jane Nick Aaron S. Daugherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 W. Franklin St. Hagerstown, MD 21740 Charlene Lloyd Social Worker 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Samples Manor Cemetery 10/11/11 Sharpsburg, MD 22. Name and Address of Facility Eackles-Spencer & Norton Funeral 21. Signature of Funeral Service Licenses M00970 Home Harpers Ferry, WV 25425 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ARTERIO SCLEROTIC CARDIO VASCULAR Physician/ disease or condition resulting in death) YRO Medical Due to (or as a consequence of): DISEASE Examiner Sequentially list conditions, if any, leading training clause cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): cal Division of Vital Records, P.O. Box 68760 Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ OASTRUCTIVE PLLMU WARY 1 Yes 2 No 3 Probably 4 4thknown Completed DISEASE WIPPATENS 10-V ANEMIA Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an certificate has the irector, page 2 s autopsy perform CORCURRAL VAICULAR the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 🕒 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A pleted filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) no mo 00 8, 20 ((D (8019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 340 Mill Street, Hagerstown, MD <u>Vasant Datta</u> M.D

DHMH 17 Rev 7/2009

State

Registrar

OCT 13 2011

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title

Susan J. 31. Date filed (Month, Day, Year)

Me

Miller,

OCT 12 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signature

29c. License number

D35579

8218 Wisconsin Ave. #305, Bethesda, Md. 20814

29d, Date signed (Month, Day, Year,

October 11, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 23a per med cert G921 11/1/11 dk
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Gould Nancy L. 2011 9:00 October Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown 1650 Pullman Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours Min 1 - M 2 X F Maryland Yrs. March 09.1939 Director 212-38-1672 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland irector Examiner must be notified at Anne Arundel Severna Park MD 1 Yes 2 X No 28a-f 靣 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Funeral USA items 23a 21146 240 Tolstoy Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 1 and 2 should be filed within 72 f Health and Mental Hygiene. Item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Home 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Erna Schneider Henry Engroff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 240 Tolstoy Lane Severna Park, MD 21146 William M. Gould/ Husband 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot cemetery, crematory or other place) October 1 🗌 Burial 2 🔀 Cremation 3 🔲 Removal from State Baltimore, MD Metro Crematory, INC. 2011 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home Signature of Funeral Service Licensee Severna Park, MD 21146 495 Ritchie Hwy, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani SUDOW disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 5 minutes Cardia Arrythmia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examine 5 years Coronary Artery Disease The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Year in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed N 1 🔲 Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Hotel 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Manner of Doath 28d. Describe how injury occurred ë work? 1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu mo rson who completed cause of death (Item 23a) (Type, Print) POEIL OM COSCUT WOREDR ST TOI 25RE Yr 170 SICIEST

State Registrar 31. Date filed (Month

strar's Signature

11-07359

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Catina Gilmore	State of Maryland / 1- For State Registrar	Certificate of	Health and Mental H Death		201	1 3418	
Physician	Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death	
Medical Examine	Catina Gilmore 4a. Facility Name (if not institution, give street and number)		b. City, Town, or Location of Death	October 1,	2011 4c. County of Death	0754 hrs	
	Good Samaritan Hospital		Baltimore	,	N/A		
Funeral		(In yrs. last birthday)	If Under 1 Year If Under 24Hrs	_	(MM/DD/YYYY) 9. Birti Foreign		
Director	212-96-1051 1_M 2\hat{X}F	39 Yrs.	Months Days Hours Min	July 7		yland	
any	Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Locati	on		<u>-</u>	10d. Inside City Limits	
* .	Maryland N/A	Baltimo	re			1 Yes 2 No	
the Maryland a or 28a-f show tified at once.	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Coun	try?	
h the h	7121 Harford Rd.		21234		USA		
or death with the Maryland or or 23a or 23a-f sho must be notified at once Funeral Director	11. Marital Status 1 Never Married 2 X Married Armed Forces?	If Ye	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto		p- 14. Race - American Indian, Black, White, etc.		
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5-0036 ed within 72 hour lygene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	-	160)			
d with (giene ther t	12th 0	Cr	ew Worker 18.Mother's Name	(First, Middle, Ma	McDonald	l's	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medical To Be Comple	Eddie Gilmore		Janny				
should he is ma attic ex	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Number or F	Rural Route Numb			
mand 2 sho sealth and tem 27 is traumati	Janny F. Gilmore (Mother 20a. Method of Disposition	,	Lincoln Dr.	Annapol Date	is, Md. 2	21401 Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 X Burial 2 Cremation 3 Removal from State	Memorial	ion (Name of cemetery, er place)	10-11	Annanalia	Ma	
altin mit. P partme	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		ame and Address of Fecility Son		Annapolis	s, Ma.	
E P P P	Lavry y. Reese	19	22 Forest Dr.	Annapo	lis, Md.	21401	
Physician // // // // // // // // // // // // //	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.			r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and	
xaminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)		g artery			Death	
	Sequentially list conditions, b						
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ed nsit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence to the conseq	uence of):		-			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit. Completed by Physician/Medical Examiner	d. UNPENDED AMENDED						
Box 68760, e death certificate be to attending physicied for use as the burnhysicied for use as the burnhysician/Med	IF FEMALE: 23b. Was decedent pregnant in the 1 □ Live high				23d. Date of delivery		
OX 6876 eath certificate attending phy for use as the I	past 12 months?	no of dooth	al death 3Ectopic pregna er (<i>Specify</i>)	incy	Month Da	ay Year	
b. Box 687(the death certificate the death certificate the attending phe ched for use as the Physician/M	1 Yes 2 No 9 V Unknown 9 Unknown			Ioo Birri			
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of Vital Records, g. Physician: The law require ther this certificate has been signered director, page 2 should be as To Be Completed				autopsy perform 1 ✓ Yes 2	ed? death?	mpletion of cause of	
tal Recidian: The certificate ector, page	25. Was case referred to medical		26.Place of Death (Check		NO	2 10	
Physici Physici r this c	103 2 100	2 FR/Outpatient			esidence 6 Other.		
in of Iding Ph. i. After 1 e funeral	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year	28b. Time of In	iury 28c. Injury at Work?	28d. Describe ho	w injury occurred		
Division of treading and after a Director: After Instance and Instance and Instance and Instance and Instance artification:	2 Accident Investigation 28e Place of Injur	y - At home, farm, street	, factory, office building, etc.	28f. Location (Str	eet and Number or Run	al Route Number, City	
DIVI pital or ours afte cral Dir filled in	3 Suicide 6 Could not be determined (Specify)			or Town, Star	te)		
the Hos the Fuo the Fuo upletely	29a. Certifier (Check only 1 Certifying Physician: To the best of my king one) 2 Medical Examiner: On the basis of examination and manner stated.						
To with	29b. Signature and title of certifier		29c. License number	[2	29d. Date signed (Mont	h, Day, Year)	
	Chief 2		O.C.M.E.		October 2, 2011		
1111	30. Name and address of person who completed cause of deal Ana Rubio MD. Assistant Medical Examin		nore Street Baltimore MF	21223			
State	31 Date filed (Month, Day Year) 32 Registrar's	0:		- 1250			
Registrar	OCT 07 2011 Geneva	Signature, par	KV				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^MOct 15. 2011 Herbert Herman Gross 10:10 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14720 Main Street Cresaptown Allegany Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) WV **Funeral** 1 🖳 M 2 🗆 F Months Days Director 217-10-7383 ′Ma√27 94 Usual Residence of Decedent 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Allegany MD Cresaptown 28a-f 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ral", or items 23a Examiner must b 14720 Main Street 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 14 Race - American Indian Black, White, etc. d Mental Hygiene. marked other than "natural", or Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify: 3 Widowed 4 Divorced WW II white Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natur any injury or other traumatic event, the Medical Eonce. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) spinning laborer Celanese Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bessie Robertson Perry Gross 19a. Informant's Name/Relationship (Type, Print)
Della Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14720 Main Street Cresaptown MD 21502 wife 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sunset Memorial Park 10/18/2011 Cumberland MD Donation 5 Other(Specify) Signature d f Funeral Servic 22. Name an Scarpelli Fullieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 ntel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner -transit Cause (Disease or linjury that initiated events resulting in death) Last and attending physician a for use as the burial-> O years Physician/Medical that the death certificate be IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 L 9 Unknown Yes 2 No the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 X death? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 2 X No Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number erson who completed cause of death (Item 23a) (Type, Print) Henn 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

6

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Avertagible. 3 Lamend #19a per FH FCHD TM 10/11/11 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 08:06 AM OR Va x to be 261 Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HODKINS tospita None Social Security Number Sex 7. Age (h yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Country **Director** 190-40-4917 1 🖾 M 2 🗆 F Yrs Feb. 21, 1921 61 Pennsylvania Usual Residence of Decede 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Maryland Frederick Ijamsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3495 Firestone Drive United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married b Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Construction injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert M. Horvatin Angelina Volpe 19a. Informant's Name/Palationship Tiggs, Prohr/Stepson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau / Son 27 Bluebird Trail 17320 Timothy Fairfield, Pennsylvania Lohr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Stauffer Crematory 10, 2011 Frederick, Maryland 21. Sig/ture of 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death in fantion Physician myorardial disease or condition Medical resulting in death) Due lo (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caces Enter Underlying Due to (or as a consequence of). Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year the i P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 12 No မ 1 patient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending n 24 hours after death.

e Funeral Director: After sletely filled in by the fur atural work? 1 ☐ Yes 2 ☐ No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatule and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 08.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30% - 1000 North Wolcest Baltimore Md 21581 MD eson

Registrar

State

egistrar's Signature

EMELAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible	341	R
AAO HEALTHate of Maryland / Department of Health and Mental Hygiene	0 1 1	

		1-For State AMEND#20b pe Registrar		11 GHC6	rtificate of	Death					g. No.		
Physicia cal Examin	ner	1. Decedent's Name (First, Midd Bruce T.	. Hall						Mc Oc	ate of Death onth ctober 8,	Day Year 2011	r	Time of Death 1712 hrs
		4a. Facility Name (if not institution Anne Arundel Medica		ımber)		4b. City, Tow Annapo		cation of [Death		4c. County o		
Funeral Director		5. Social Security Number 193–28–0839	6. Sex	7. Age (In yrs. 74			Year Days	If Under 2 Hours		01/19	h(MM/DD/YYYY) /1937	Foreign	ace (State or y) Pennsy1va
Maryland 28a-f show any d at once.	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne 10e. Street and Number	Arundel	10c. City	, Town or Locat	Anna		is		10	ng. Citizen of Wh	1	d. Inside City Limits Yes 2 XX No
er death with the l , nr items 23a nr r must be nntiffe	Funeral Director	843 Harbor Vi	12. Was De Armed F	cedent Ever in U orces?	If Y	is Decedent of es, specify C	of Hispa Juban, N	Mexican, P	? (Specify	Yes or No-	USA 14. Race White	- American	Indian, Black,
D-UUSD led within 72 hours aft dygiene. nther than "natural" tte Medical Examine	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)		de completed)	16a. Deceder	nt's Usual Oc ost of workin	cupation g life. D	Give kin	se retired)		16b. Kind of Bus	siness/Indu	
Z1Z13-0U36 uld be filed within 7 Mental Hygiene. marked nther than c event, the Medica	å	17. Father's Name (First, Middle Joseph C. I	Hall		19b Mailin	n Address (Sai	ra L.	Wiest	Maiden Surname) t ber, City or Town		n Code)
e, MU	۲	Winnie S. Hall 20a Method of Disposition	11 - Wife			Harbon	· Vi	ew Te		e, Ani	napolis,	, MD 2	21409
ESAUTHOFE, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traus		1 Burial 2 Cremation 4 Donation 5 Other S 21. Signature of Funeral Services	Specify:	om State Ba	ltimore	Crema	dress o	f Facility	John	2/11 M. Ta	Baltimo	inera]	liome
Physician /Medical xaminer		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	e on each line.		h. Do not enter t	he mode of d	ying, su	ich as card				art /	MD 21401 Approximate Interval Between Onset and Death
cuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence									
cate be execut physician and the burial - trai	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery								delivery			
DIVISION OF VICAL RECORDS, P.O. BOX 80/80, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		23b. Was decedent pregnant in t past 12 months?	the 1 Live	oirth nant at time of d	2 Fe	etal death ther (Specify		Ectopic p	pregnancy		Month	Day	Year
quires that the en signed by the lid be detached	2	Part II. Other significant condi End stage renal dise			resulting in the	underlying ca	iuse giv	en in Part	_ [2 No 3	Probab	ly 4 ✓ Unknown
or Vical Recolus, ig Physician: The law requin. Ufer this certificate has been s meral director, page 2 should t	Completed									autop perfor 1 V Yes	rmed?		pletion of cause of
ysician ysician his certi	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	17 27 1	Inpatient 2	ER/Outpatient				Check only only on the Nursing Horon		Residence 6	Other:	
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To the Hospital or Attendia within 24 hours after death. To the Funeral Director: /	Certification:	4 Homicide dete	28e. Place (Specify) Physician: To the be)	home, farm, stre					or Town, S	itate)		Route Number, City
To the Ho within 24 h To the Fu	Medical	(Chack only Certifying F	aminer: On the basis and manner	of examination	and/or investiga	tion, in my op	oinion, o	death occu	urred at the	time, date	and place, and d	lue to the c	ause(s)
H % H %	Me	29b. Signature and title of certifications		au			icense).C.M	number .E.			29d. Date sign October 9,		, Day, Year)
5+1		30. Name and address of person Carol Allan, MD As	n who completed cau ssistant Medical	•		timore St	reet, E	Baltimor	e, MD 2	1223			
Sta Registi	ate	31. Date filed (Month, Day, Year	2011 32.8	gistrar's Signa		aked							
/H 17 Rev 1/20			OGME		ORIGINA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Johnson Physician/ ames 0030 tober 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns HOPKINS HOSPITA None Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Director 213-36-4333 1 🔀 M 2 🗆 F 73 09/28/1938 MD 28a-f show 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Howard Clarksville or items 23a or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13751 Triadelphia Mill Road 21029 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2x No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 'natural", If Yes, Give Specify. 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) 12 College (1-4 or 5+) and Mental Hygiene. event, the Inspector WSSC is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Howard General Johnson Mattie Ridgley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Wayne Johnson - son 5010 Ten Oaks Road Clarksville, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important; If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) Linthicum Chapel Cem. 10/17/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. any in once. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Dav Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? After this certificate 1 Yes 2 No 1 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dec. Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St. Baltimore MD 21287 strar's Signature State OCT Registrar

11-07660 George Koons Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

George Koons	1- For St	tate	tate of Maryla		artment o <i>rtificate o</i>			Menta	al Hy		Reg. No.	201	1 1	3418
Physician		ı r dent's Name (First, Midd	fle,Last)				·		2	2. Date of Dea	ath	Year	3. Time of	
Medical Examine		orge Eugene Ko								Month October			0506	hrs
		lity Name (if not institution 1909 Virginia Avenu		ımber)		•	rstown rstown	ocation of	Death			unty of Deat hington	h 	
Funeral		Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Und	er 1 Year s Days	If Under	24Hrs. Min.	8. Date of Bi	irth(MM/DD/	Forei	an	
Director		-30-5174	1 XXM 2 F		70 Yrs		Days	nouis	IVIII I.	Dec.2	3,1940) C	ountry) Pen	nsylvani
È	Usual R 10a. Sta	esidence of Decedent ite 10b. County		10c. City	, Town or Local	tion	_						10d. Inside	e City Limits
P 00 41	West													s 2XXNo
uylanı Sa-f si	10e. Str	ginia Ber	rkeley	<u> Fa</u>	lling W	Vater 10f.Zip				1	10g. Citizen	of What Cou	L	
he Ma iffed 1	257	Imperial W	Wav				2541	L9			US	A		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Elineral Director	11. Mari	tal Status	12. Was Dec	edent Ever in U	.S. 13. Wa	as Decede	nt of Hispa	anic Origin	? (Spe	cify Yes or No	0- 14.1	Race - Ame	ican Indian,	Black,
death or iter	⋚ <mark>│</mark> ¹╚╚	lever Married 2 🕮 M	1XX Yes	2 No				Mexican, P	uerto R	tican, etc.)		White, etc.		
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nour:	15. De	cedent's Education (Spe entary/Secondary (0-12)			16a. Deceder during m	nt's Usual nost of wo	Occupation king life. D	on (Give kir DO NOT us	nd of wo	ork done ed)	16b, Kind	16b. Kind of Business/Industry		
136 hin 72 e. etical		12	Joinege (1	-40101)	Carpen	iter/	Engir	neer			U.S	. Mili	tarv	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Element 17. Fath	er's Name (First, Middle	, Last)						Name (First, Middle,	_1			
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Baltimore, permit. Pages 1 ar Department of Hea Important: If ite, injury or other tr	1 🗆 B	Burier 2XX Cremation		om State	crematory or ot	ther place)		•				•		
it. Pagirmeni remeni remeni y or o	4 Donation 5 Dotter Specify: Hagerstown Crematory 10-17-2011 Hagerstown Signature of Fureral Secondary 22. Name and Address of Facility Osborne Funeral Ho									_	Iana			
Ba Depa Impo	Z	attag of the fall of the	Licensee							rne Fu St.				21795
Physician		t I. Enter the disease, or ure. List only one cause		aused the death	. Do not enter t	the mode	of dying, s	uch as car	diac or r	respiratory an	rest, shock, o	or heart	Approxim	nate Interval
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į	cause. (Disease	Enter Underlying Cause e or injury that initiated	С	The Seans										
ited Jansit	events r	esulting in death) Last	Due to (or as a	consequence of	of):									
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3760 ficate g phys s the b	IF FEMA	s decedent pregnant in the		outcome of preg	. —	etal death	3 [Ectopic p	recnan	CV.	23d. Da Mon	ate of deliver	y Day	Year
Box 6876(e death certificate the attending phy; ed for use as the b	past	t 12 months?	4 Pregn	ant at time of de	ath -	ther (Spe		_сооріс р	ognan	-y	l wo	101	Day	real
b. Box 6876 the death certificate by the attending phy ched for use as the l			known 9 Unkno								11			
i, P.O. Box 6 ires that the death cer signed by the attendi be detached for use	<u> </u>	Other significant condit	tions contributing to	death but not r	esulting in the u	underlying	cause giv	en in Part	l. 		obacco use o			
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Vital Recysician: The Inis certificate I director, page		case referred to medica					26. Place o	of Death (C	heck or					
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Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	3	Suicide 6 Coul	not be	e of Injury - At h		et, factory	office bui	ilding, etc.		8f. Location (State)			umber, City
Lospita 4 hours by fille	' 'YYa Cer	tifier 4 Continue B	Physician: To the bes	Local Street		πed at the	time date	and place		6909 Virgini				
To the Ho within 24 to To the Fu completely	(Check or one)	",	aminer:On the basis of and manner st	of examination a	-									
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the day		e and address of person				ima	·4	14!		04000	•			
M-241			sistant Medical E		900 W. Balt	imore S	ireet, B	aitimore	, IVID	Z1ZZ3				
Stat Registra	(# 31. Date	filed (Month Care)	4 2011	gistrar's Signatu	1	The same	1							

ORIGINAL

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11-07729 Robin Kienzle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robin Kienzle	1- For State	Maryland / Departmo <i>Certific</i> a			Mental		Reg. No. 2	111 31.18		
Physician/	1. Decedent's Name (First, Middle,Last)					2. Date of De		3. Time of Death		
Medical Examiner	Robin Leigh Kienzle					October	15, 2011	0835 hrs		
	4a. Facility Name (if not institution, give street 490 Greenwood Street	et and number)		City, Town, or Lo O denton	cation of D	eath	4c. County of I			
Funeral	5, Social Security Number 6. Sex	7. Age (In yrs. last birt	-	If Under 1 Year	If Under 2		Birth(MM/DD/YYYY)	9. Birthplace (State or		
Director	217-82-8951 _{1_M}	2₹XF 48	Yrs.	Months Days	Hours	Min. 5/3/	1963	Foreign Country) Utah		
8	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limits		
low any	MD Anne Arun			enton				1 Yes XX No		
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	10e. Street and Number		1	Of. Zip Code			10g. Citizen of What	Country?		
the M sa or 2 biffed	490 Greenwood St.			2111	USA					
th with		Was Decedent Ever in U.S. Armed Forces?		ecedent of Hispa specify Cuban, N		14. Race - American Indian, Black, White, etc.				
ter dea	3 Widowed 4 Divorced If Ye	Yes 2XX No	1 Ye	es XX No	specify:	Specify:	White			
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5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12)	College (1-4 or 5+)		Tech	O NOT USE	remed)	Veter:	inarv		
-003 d withing the the the the the comp	17. Father's Name (First, Middle, Last)		700		.Mother's N	lame (First, Middle	e, Maiden Surname)			
215 be filed ntal Hy rked of cut, th	George O'Mara	Lane								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Keith Kienzle		_	•			umber, City or Town,	State, Zip Code)		
mand 2 s and 2 s ealth a traum	20a. Method of Disposition	20b. Place of	of Dispositio	n (Name of ceme		Date Date	MD 21113	ity or Town, State		
nore	1 Burial 2 XX Cremation 3 R	onno ran monte ottato	ory or other	place) rematory	,	1/23/201	.1 Glen B	urnie. MD		
altin mit. P. partme portan ury or	4 Donation 5 Other Specify: 21. Signature of Funeral Secretaria	4277					Funeral Ho			
Der Der Eigen	23a. Part I. Enter the disease or complication					-				
Physician //Medical	failure. List only one cause on each lir	e.						Approximate Interval Between Onset and Death		
≛xaminer		rdiac Arrhythmi o (or as a consequence of):	a ass	ociated	with	Cardiome	eagaly	Dodai		
	Sequentially list conditions, b									
nine	if any heading to immediate Due to cause. Enter Underlying Cause (Disease or injury that initiated	o (or as a consequence of):								
ted 1 nnsit Examiner	events resulting in death) Last Due t	o (or as a consequence of):								
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760, sate be physici he buri	IF FEMALE: 23	c. If yes, outcome of pregnancy					23d. Date of de	alivery		
). Box 6876 the death certificate oy the attending phy ched for use as the Physician/M	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of death		death 3 · (Specify)	Ectopic pr	egnancy	Month	Day Year		
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tedical Certification: To Be Completed by Physician/IM	Part II. Other significant conditions conf	ributing to death but not resulting	g in the und	erlying cause give	en in Part I.			robably 4 V Unknown		
ds, F quires en sign uld be						— 24a. Wa		ere autopsy findings available		
Records, : The law requires firate has been sig f, page 2 should be Completed			-		-	per	formed? dea	or to completion of cause of ath?		
Vital Rec ysician: The l his certificate l director, page	25. Was case referred to medical			26.Place o	f Death (Ch	neck only one)	s 2 No 1	Yes 2 No		
f Vital Physician r this certi ral directo	examiner? Hospit	al: 1 Inpatient 2 ER/O	utpatient 3	DOA O	ther ₄ N	ursing Home 5	Residence 6			
n of Vijuing Physical After this funeral dir	1 X Natural	28a. Date of Injury (Month, Day,Year)	Time of Inju		at Work?		e how injury occurred			
Sion Attenor death r death ector: by the	2 Accident Investigation	28e. Place of Injury - At home, fa	arm street				(Street and Number	or Rural Route Number, City		
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the edical Certificatif	29a. Certifier 1 Certifying Physician:	o the best of my knowledge, de								
To the Ho within 24 I To the Fu completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
Ž Ž	Live Live	P		O.C.M			October 16,			
	30. Name and address of person who comp									
Ow	Ling Li, MD Assistant Medic	al Examiner 900 W. B	altimore	Street, Baltin	nore, MD	21223				
State Registrar	31. Date filed (Month, Day, Year) 2011	32. Registrar's Signature	bar	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kilgore A^M October 2:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7920 Roxbury Drive Anne Arundel Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country)
Virginia 1 □ M 2 🂢 F (Month, Day, Ye) June 25 Months Hours 217-26-6827 89 Director <u>June</u> Usual Residence of Decedent show the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified. MD Anne Arundel Glen Burnie 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a 7920 Roxbury Drive 21061 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bessie Rasnick James M. Counts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggie Glenn/ Daughter 7920 Roxbury Drive Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Memorial Gardens ö permit. Page Department of Important: If any injury or October 4 ☐ Donation 5 ☐ Other (Specify) 2011 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart latiture. List only one cause on each line. Immediate Cause (Final ALTHEIMEN Physician, Onset and Reaths disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of, -transit and resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death Year the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed ! 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be ANTERIOSCLEPOSIC CAVE DIOVASCULAR 2 No 3 Probably 4 Unknown 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perform 1 Yes 2 No 25. Was case referred to medical Be DADINTER 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 Tes Home 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' ithin 24 hours after death.

the Funeral Director: All ompleted filled in by the fu death. Accident
Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGAMIN MINJIJANINA JKING M 5/P B State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCT.19, Day 011 Physician/ GLADYS ELAINE KELLEY 10:30A M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST MARY S ST.MARY'S HOSPITAL LEONARDTOWN Social Security Number If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav **Funeral** Hours 1 □ M 2 屎 F Months 219-56-1220 58 **Director** 6-21-1953 OHIO Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 ☐ No MD. ST.MARY'S LEXINGTON PARK 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 45645 MIDWAY DRIVE 20653 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MONUMENTAL LIFE CO. INSURANCE SALESMAN 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ERNEST WARD KIDWELL UNA DELL SPENCER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LINDA SLATTERY-SISTER 9567 KLINE DR. LA PLATA, MD. 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 10-24-11 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GARDENS WALDORF, MD. 21. Signature of Fureral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYDAND 20646 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus, on each line. Approximate Interval Between et and Death Immediate Cause (Final SPIRATORY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) PNEUMONITIS Examiner INTERSTITIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral d rector, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SYSTEMIC SCLEROSIS 2 No 3 Probably 4 Unknown Division of Vital Records. 1 🗆 Yes CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HRIERY DISEASE CORONARY 1 Yes 2 No 25. Was case referred to medical examiner? within 24 hours at er death.

To the Funeral Director: After this certific completed filled i by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital 1 Inpatient 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check The distance of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar ST. MARY'S HOSPITAL

32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATRICIA GURNY, MD

>26344

LEONARDIOWN, MARYLAND

GOBER 19, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 9 Day 2011 Year 10:05 AM Therese Agnes Lodge Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 3116 Gracefield Road, #VP T-16 Social Security Number 7. Age (In vrs. last birthday f Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth 1 🗆 M 2 🗓 F Days April 9 470-26-6675 **Director** 82 Usual Residence of Decedent or 28a-f show with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 3116 Gracefield Road, #VP T-16 20904 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. White 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jacob Dech Elizabeth Gillen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 Gracefield Road, #VP T-16, Silver Spring,MD Robert W. Lodge/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State Oct. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 201 Signature of Juneral Service Licen 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. MD 20901 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hyperlipidemia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 XNo 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 Yes 2 No death? certificate within 24 hours after death.

To the Funeral Director: After this certific sempleted filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 🛛 Residence 6 🗌 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident Investigation 1 🗌 Yes Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifie

30. Name and address of person

31. Date filed (Month, Day, Year)

Anjana Dhar, Mi

mpleted cause of death (Item 23a) (Type, Print)

D0061146

10301 Georgia Avenue, #301, Silver Spring MD 20910

29d. Date signed (Month, Day, Year)

10-10-2011

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10-04-2011 2:30 P Percy Bertolette Lewis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner William Hill Manor Easton Talbot 8. Date of Birth (Month, Day, Year) 08-19-1925 Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days 1 X M 2 □ F 86 218-34-9772 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County if than "natural", or items 23a or 28a-f show the Midical Exercities must be nutified at 1 ☐ Yes 2 🔯 No Director Caroline Preston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 4256 Payne Rd 21655 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Farmer Agriculture permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other than any injury or other traumatic event. It. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Percy Marr Lewis Catherine Taylor ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nellie Elizabeth Lewis (wife) 4256 Payne Rd Preston, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Cremation
Center Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-05-2011 | Stevensville, MD 21. Signature Funda 2 rvice L Fellows, Helfenbein & Newnam Funeral Home P.A. 200 S. Harrison St. Easton MD 21601 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) UROSEPSI DAYS **Physician** /Medical Examiner INFECTION cuspotietly list or nythy or if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC RENAL INSUFFICIENCY, þ 2X No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an was a... autopsy performed? After this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending (Month, Day, Year) Injury 1 X Natural 5 ☐ Pending 1 □Yes 2 □ No investigation 2 Accident To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number -TTENDING MID who completed cause of death (Item 23a) (Type, Print) 321 BLOOMINGDALE AUE FEDERALS BURGEM 21637 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 8 2011 Dorothy Jean Brinkman Lewis 7:56 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Frederick 7958 McKaig Road Frederick Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth April 30, 1931 Maryland 1 □ M 2X F Min. 80 Director 214-28-6988 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2 🕱 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7958 McKaig Road 21701 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elsie Estelle House Wilbert Eugene Brinkman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $3217\ Atlee\ Ridge\ Rd.,\ New\ Windsor,\ MD\ 21776$ Jeanne K. Lewis / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. Date 0. cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory Frederick, Maryland 2011 Signature of service Licenses Skkot Cody P.A. Frederick, MD 21701 Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or shock, or neart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition 1 Week Death Physician/ Cerebral Vascular Accident Medical resulting in death) Due to (or as a consequence of) Examiner 10 years CAO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Atrial Fibrillation l year Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical 5 years COPD Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 XXNo Month Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 XX Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No 1 Yes 2 No after death.

Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 🗌 Yes 2 🗆 No 5 Pending Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) mail October 10, 2011 D 46248

DHMH 17 Rev 7/2009

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Registrar

300 West 9th Street, Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Martha J. Pierce, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Cassandra Love Octobe. 1655 0 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Agnel Baltimore HOSPITAL Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 😾 F Hours 577-66-1760 1947 Washington, DC **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must hamatic and any injury or other traumatic event, the Medical Examiner must hamatic at the matter and any injury or other traumatic event. 28a-f shov 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 Yes 2 X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 7608 Amore Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: **Black** 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Claims Officer Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Helen Adams Reginald Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7608 Amore Circle, Catonsville, Maryland 21228 Ezekiel Love, II-SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Maryland National Cemetery Oct. 7, 2011 Laurel, Maryland 4 Donation 5 📮 Other (Specify) 22 Name and Address of Eacility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 21. Signature of Funeral Sei NOIT 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List anly one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Unknown Medical resulting in death) Examiner Diagonal and Spirit Onknown Sequentially list conditions, if any leading to increase Examine cause. Enter Underlying Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-transit Unknown Sevue anemia that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical pelmonasy Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 1 Yes 2 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? shock liver failure 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗌 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examinor? Other: 2 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Division 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours and To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Dux 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Vadipelli 900 2 ·Caton trenue.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

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strar's Signature

Mosner, Office L TR Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oliver Lewis Mosner, Jr. 1 2011 Medical 4a. Facility Name (if not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Worcester Ocean Pines 9 Capetown Rd. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Age (In vrs. last birthday) Days 1 🗷 M 2 🗆 F Hours Min. (Month, Day, Year Country) MD **Director** Usual Residence of Deceden 28a-f show 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21811 9 Capetown Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 🗶 Yes f Yes, Give 2 🗌 No Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 Widowed 4 K Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Trucker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Eleanor May Triplett Oliver Lewis Mosner, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Pinewood Dr., Somersworth, NH 03878 Rachel Mosner / daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem. 10/12/11 Millsboro, DE 21. Signa of Funeral Service Lic 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence /f) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Cericadid 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

hysleign

830 32. Regetrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DO0 522

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Sarah Frances Mayor 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washingto uthern avenwood Hasei f Under Oyear ev Villago 8. Date of Birth (Month, Day, Year) July 27, 1918 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 1 □ M 2 🛛 F 93 Months Days Hours Maryland 579-38-0100 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland featth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State other traumatic event, the Medical Evaminer must be notified at Washington County Maryland Williamsport 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16901 Hampshire Dr. 21795 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 X Married 1 ☐Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Doctor's Office Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Tompkins Abell Sarah Edith Morris Abell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traconce. Mary Marcia Mayor-stepdaughter 16901 Hampshire Dr. Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 10-13-2011 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 artlin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician emorany mbales 2 chayo disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performe 2 No 1 ☐ Yes 1 ∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. n 24 hours after death.
e Funeral Director: Aft letely filled in by the fur within 24 hountly to the Funer completely file

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Street - Hergeston 190

29d. Date signed (Month, Day, Year)

10-12-11

29b. Signature and title of certifier

HAIR 368 -AR 31. Date filed (Month, Day, Year 32. Registrar's Signature

29c. License number

028365

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Octob<u>er</u> Physician/ Gabrielle Marcoullier 12:00P Medical Facility Name (if not institution, give street and number) 4a Facility Name (IF FIGURE 1993) 48 Fargo Avenue Examiner 4b. City. Town, or Location of Death 4c. County of Death Oxon Hill Prince George 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min (Month, Pay, Year 5/20/1925 1 □ M 2 🗓 F 86 Months Hours 099-24-5175 Director Germany Usual Residence of Decedent 28a-f show 10b. County and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director Maryland Prince George Oxon Hill 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5636 Fargo Avenue Funeral 20745 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🗓 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Librarian P.G. County Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is mediany injury or other. ဂ Hilfsarbeiter S. Josefine Konig Wohnhaft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eddie Henderson/Per. Rep. 38885 Sage Place, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 🔏 🛣 Cremation 3 ☐ Removal from State Kalas Crematory of other p 10/10/2011 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final PE Onset and Death Physician/ RTEN disease or condition Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Live Fetal 3...
Pregnant at time of death in the past 12 months?
1 Yes 2 No Month Day Year signed by the a Id be detached f 1 ☐ Yes ∠ m 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Yes Yes To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mont

TAK DA G-06 CLINTON, MD 2073.

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 9Day 2011Year Physician/ 8:00 Рм **Blanche** F. Nagro Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** P.G. Hillhaven Nursing Center Inc. Adelphi If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 28, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min 1 □ M 2 🔼 F 578-12-5966 91 Director May D.C. Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director or 28a-f sl 1 ☐ Yes 2 🔀 No MD P.G. College Park 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral Place 20740 USA 9201 Limestone 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Completed by 1 Never Married 2 Married Specify.White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. 3 X Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John A. Foreman Blanche Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Nagro/Son 9201 Limestone Place, College Park, MD 20740 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 0ct 13 1x Burial 2 Cremation 3 Removal from State 2011 Gate of Heaven Cemeterly 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Francis J. Collins Funeral Home 500 University Blvd. W., Silver Signature of Funeral Service Licensee MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to Thrive Medical resulting in death) Due to (or as a consequence of) **Examiner** Dementia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician the buris Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) signed by the a ld be detached for 9 Unknown 9 Unknown P.O. I Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been siç ; page 2 should b Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific appleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: AXX Nursing Home 5 - Residence 6 - Other (Specify 2 X No မ ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 30. Name and addres

3 🗍 29b. Signature and title of cert

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Neff William

				Plea	se Type								•		_	ible.	
		,	For State		State	e of M	arylan		artmei <i>tificat</i>			and M	lental Hy	0	00	7 1	21.100
			Registrar 1. Decedent's Name	(First, Middle	, Last)			007	tincat	C 01 L	Catri		2. Date of D		lo.		3. Time of Death
	Physicia Medic		William	James	Neff J	r.							O Honth	ZEN	5 a	Year	3.Time of Death 03.05A _M
	Examin	er	4a. Facility Name (if n		•	,					Location	of Death			c. County		
	Funeral		Baltimore 5. Social Security Nur		6. Sex	7. Ac		nter ast birthday)		r 1 Year	If Under		8. Date of Bi	rth	nne .		deL nplace (State or Foreign
	Director		212-78-07		1 🗙 M 2 □	F	52	Yrs.	Months	Days	Hours	Min.	04726	7195	9	Mar	YYand
	and show lat	ō	Usual Residence of D 10a. State	10b. County			10c. City	y, Town or Lo	cation								10d. Inside City Limits
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	eath w tems ? er mus	Fune	11. Marital Status	- Incudor	12. Was D		Ever in U.S	3. 13. \				gin? (Spe	cify Yes or No Rican, etc.)	-			ican Indian,
21215-0036	je 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 Never Marrie 3 Widowed 4	X Divorced	ied 1 🗌 Y If Yes, Year o	Forces? es 2 X Give r Dates.	No	1 -			n, Mexicar Specify:		Rican, etc.)		Black, White, etc. Specify: White		
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Maryland	e filed ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)										?)				
ž	ould b nd Mer mark imatic		William 19a. Informant's Nan					10h Mailir	a Addres	(Street o		y Wa	ters Route Numb	or City	ar Town C	toto Zin	Cadal
	id 2 sh salth ar n 27 is er trau		William J			Son							rn,MD			tate, zip	Code)
Baltimore,			20a. Method of Dispo 1∰ Burial 2 □	Cremation	3 🗆 Removal fi	om State	20b. P	lace of Dispo emetery, cren	sition (Nai	ne of			ate			City or 7	Town, State
Itim	permit. Page : Department of Important: If i any injury or once.		4 Donation 5	5 🗌 Other (S	pecify)	1		dwin M					9/2011				
Ba	Depi Imp		> Gay	7	////			F	larde	sty !	Funer	al H	ome P.	A. Ga	ol Ani umbri	napo IIs,	lis Road MD 21054
	Physician/	83 19	Immediate Cause (Fi	failure. List o inal	complications the	at caused each line	the death	Do not ente		7 î		~	r respiratory a	rrest,			Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)		a. Due	to (or as	a consequ	ence of):				JAV	1000			\dashv	
		er	Sequentially list cond	ditions,	b.	to for an	a sonsequ	ense till									
	uted Id ansit	Examiner	cause. Enter Underly Cause (Disease or iir that initiated events	ying njury	G	(-, -,-											
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68760	cate b physic s the b	edic			d												
89 ×	ending use as	an/M	IF FEMALE: 23b. Was decedent p		23c. If yes,			ncy Ideath 3	Ectonic	nreonanc					23d. Dat	te of deli	very
. Box	Physician: The law requires that the death certificate be this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the bi	Physician/Medical	in the past 12 mo 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 🔲 P		t time of d		Other (s)		,				Moi	nth	Day Year
P.O.	that th	by Pł	Part II. Other signific	ant conditio	ns contributing t	o death b	out not resu	ulting in the u	nderlying	cause giv	en in Part	l.	23e. Did	tobacco	use contr	ibute to	the cause of death?
of Vital Records,	requires been sig should b	ted											1 🗆	Yes 2	2 🗆 No	3 🗆 Pro	bably 4 Unknown
ooa	e law n has b ge 2 sh	Completed											24a. Was	psy	/ F	Vere auto prior to co death?	opsy findings available ompletion of cause of
E E	sician: The la certificate ha rector, page	Be Co	25. Was case referred	to medical	_	-7			_	26 Pla	ace of Deat	th (Check	1 Yes	2	No 1		2 No
Vit	hysician; his certific I director,	To B	examiner?	No	Hospital:	Inpati	ent 2 🗆	ER/Outpatien	t 3 🗆 D	Othe	ir.		ne 5 🗆 Resi	idence	6 🗆 Othe	er (Specif	y)
n of	ding h. After fune	cate:	27. Mann of Death 1 Vatural 2 Accident	5 Pending	g (N	ate of inju Ionth, Day		28b. Time of injury	M 2	8c. Injury work 1 🗆			8d. Describe	how inju	iry occurre	ed	
Division	or Atter frer des firector in by the	Certificate:		6 Could r	not be 28e. Pla		ury - At hor c. (Specify)	me, farm, stre	eet, factor	, office		2	28f. Location (er or Rura	al Route Number,
۵		Medical (29a. Certifier 1	Certifying	Physician: To the	e best of	my knowle	edge, death o	ccured at	the time,	date and p	olace, and	due to the ca	ause(s) a	and manne	er as stat	ed.
	To the H within 24 To the Fi complete	Me	only one) 3 29b. Signature and tit	Certifying	Nurse Praction	er: To the	best of my	knowledge, o	leath occu	my opinio rred at the License	time, date	and place	e, and due to the	ne cause	e, and due e(s) and ma ate signed	nner as s	
	5>		► As	orge	E. U	hi	KI	20 M.D	3	1) ?	113	65		Oc	tob	ev -	5, 2011
	9		30. Name and addres	s of person v	/ho completed c	aus of d	eath (Item	23a) (Type P	rint)	301	du	500 B	hall	PVI	MD	ス	0161
	Stat Registra		31. Date filed (Month,	Day, Year)	2011	- Pegistra	ar's Signati	B. As	ark	1		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-07540 Martin Sean O'Toole State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 8, 2011 1125 hrs Medical Examine Martin Sean O'Toole c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 5401 Westbard Avenue #1207 Rethesda 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 5. Social Security Number **Funeral** oreign Country)Pennsylvania Months Days Hours Director 1 M 2 F Yrs 177-52-1290 38 6 1973 Usual Residence of Decedent 10d. Inside City Limits P.D. 10b Count 10c. City, Town or Location Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28s-f show
Injury or other trannatic event, the Medies Examiner must be notified at sonce. 1 Yes 2 X No Maryland Bethesda rector Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 靣 5401 Westbard Avenue, Apt 1207 20816 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2X No Yes If Yes, Give Year 1 Yes 2 X No specify: Specify: White 4 Divorced ੬ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Trade School Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn C. Mills O'Toole Martin J. O'Toole 19a, Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10109 Ridge Manor Terrace, Damascus, MD 20872 of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Evelyn C. O'Toole, Mother 20b. Place of Disposition (Name of cemetery. 20a. Method of Disposition crematory or other place)
Metropolitan
Crematorium, Inc. Burial 2 XCremation 3 Removal from State Oct.12,2011 Alexandria, Virginia 4 Donation 5 Other Specify 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home 21. Signature of Funeral Service Lice 26401 Ridge Road, Damascus, MD 20872 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and /Medical Death a Contact Gunshot Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. ner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED ed by the attending physician detached for use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been sector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed death? ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical director. 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Mursing Home 5 Residence 6 🗸 Other, Scene this 1 Yes funeral 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self 1 Natural FOUND: 1 Yes 2 ✔ No 5 Pending within 24 hours after death To the Funeral Director: in by the Oct 8, 2011 1111 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 5401 Westbard Ave., #1207, Bethesda, MD determined (Specify) Multi-Family Apt. 4 Homicide 29a. Certifier (Cfleck only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10

OCME 2006

State

Laron Locke MD 31. Date filed (Month, "Day Year) 29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

October 9, 2011

me and address of person who completed cause of death (Item 23a)

OCME

and manner stated

Assistant Medical Examiner

32 Registrar's Signature

-ABCA-A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2011 9:13 Α October Jetta Mae Osborne Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Gilchrist Hospice Care 5. Social Security Number Birthplace (State or Foreign Country) . Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Ye **Director** 9 1928 <u>Pennsylvania</u> 160-22-3911 May Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Columbia 1 Yes 2X No Howard 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 10621 Hunting Lane 21044 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force 1 Never Married 2 Married þ Yes 2x No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other ပ Estella Bishop Charles Nelson Yost 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Samuel Rush Osborne/husband 10621 Hunting Lane Columbia, Maryland 21044 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Gar.10/17/2011 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc Signature of Funeral Service Licenses MD 21043 4112 Old Columbia Pike Ellicott City, Thomas 23a. Part Denter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 1 Yes 2 No this certificate Yes 25 25. Was case referred to medica 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence P 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: 1 Natural Natural
Accident
Suicid iniury 5 Pending 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 24 hours after death. To the Funeral Director: After To the Hospital

> 15 State

сопрете

Registrar

Medical

29a. Certifier

BINDU.

3 = 29b. Signature and title of certifier

JOSEPH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6336

CEDAR

1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0060634

COLUMBIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Pollack 10:30a M Fannie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Sunrise Assisted Living-Silver Spring Silver Spring If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) New York 1 □ M 2 🕱 F Months Days Hours 102 **Director** 143-26-7196 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20901 u.s.A. 8608 Geren Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give White Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Dora Stern Human Birnbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8608 Geren Road, Silver Spring, Maryland 20901 Susan Moran - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🛣 Removal from State Beth Israel Cemetery 10/12/2011 Woodbridge, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service 22. Name and Address of FacilityHines-Rinaldi Funeral Home, New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Dusphagia Sequentially list conditions, if any, leading to immediate Examiner attending physician and a for use as the burial transit Recurrent Urinary Tract Infection To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Debility Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanced Age 102 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I this certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Assisted Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) Hospital 1 Tyes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA Living 28a. Date of injury (Month, Day, Year) After thi 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending within 24 hours after death

To the Funeral Director: / Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3[only one) 29b. Signature and ti of certifie 29d. Date signed (Month, Day, Year) D35579

State Registrar 8218 Wisconsin Avenue, #305, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Susan J. Miller,

31. Date filed (Month, Day, Year) 0CT 12 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ C tober McKenzie Mila Parker Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** more 5. Social Security Numbe Unk If Under 1 Year If Under 24 Hrs. 2. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Year 2011 Month Day, Months Hours Min. Director Maryland Sep. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hipury or other traumatic event, the Medical Examiner must be notified at any hipury or other traumatic event, the Medical Examiner must be notified as 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Prince George's Cheltenham Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20602 10610 Terraco Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 X Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) lna Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shonda Summerson Monroe Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10610 Terraco Terrace Cheltenham, MD 20602 Monroe Parker/ Father 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemeters, crematory or other place)
Adams United Hethodist 20c. Location - City or Town, State 10/8/2011 | Lothian, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funer of Switz, Licens 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions cause. (Disease or iinjury Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate Yes 2 X N 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ျှ 1 🗌 Yeş 1 X Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	State of Ma						s Are Leg	gible.			
		1 - State Registrar 1. Decedent's Name (First, Middle, La	41	_	Cert	tificate of E	Death		Reg. No. 2	0	34203		
Physi		LARRY F	PADE	> Y				2. Date of Dea Month	Day	Year 2011	3. Time of Death 9:45 A M		
	dical niner	4a. Facility Name (if not institution, give	e street and number)	-		4b. City, Town, or	Location of Death			y of Death	1		
		Anne Arundel Mo 5. Social Security Number 6. S		cer	oirthday)	Annapo1 If Under 1 Year		8. Date of Birt		Arun	de1 place (State or Foreign		
Funer Direct			1 X M 2 □ F	68	Yrs.	Months Days	Hours Min.	02/21/17		Mary			
how	٦ اة	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loca	ation					10d. Inside City Limits		
Ra-fs	Director	MD Anne Art	unde1	Edger	water						1 🗆 Yes 💥 No		
perimit. Tage I and 2 should be fired within 12 hours after death with the waryand binepartnent of Health and Mental Hygiene. Inparatrient of Health and Mental Hygiene. Inparatrie firem 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ralDi	10e. Street and Number				10f. Zip Code 2103	7		10g. Citizen of		ntry?		
tems 2	Funeral	1624 Marlboro Ro	12, Was Decedent Ev	ver in U.S.	13. W	as Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-		ce - Ameri	can Indian,		
l', or i	l by l	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 N If Yes, Give	No	1	Yes, specify Cuba	n, Mexican, Puerto Specify:	Hican, etc.)	Bla Specif	ack, White,	etc. ite		
natura ical Ex	letec	3 XWidowed 4 ☐ Divorced 15. Decedent's B		110		ent's Usual Occupa			16b. Kind of I				
han "r Be Med	Completed	(Specify only highest grant (0-12)	rade completed) College (1-4 or 5-	+)	life. DO	NOT use retired)	luring most of wor	king					
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hental rrked c tic eve	P	Eldridge Paddy					Hazel D		Walder Garriar	10)			
and N and N is me		19a. Informant's Name/Relationship (1	7		and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code)		
Health tem 27		Bonnie Marie Belt	t Daughter	20b. Place		Cedar L	ane Edg	ewater,M	D 21037 20c. Location		own. State		
nent of nert, if i		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		ceme	etery, crem	atory or other plac Episcopa	· !	0/2011		ian,M			
Departmus ny inju	uce.	21. Signature of Funeral Service Licen					<u>_</u>						
2 L = 6	0	22. Name and Address of Facility Hardesty Funeral Home P.A. Annapolis, M. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
hysicia	n/	shock, or heart failure. List only one cause on each line.											
Medic xamin	al	Immediate Cause (Final disease or condition resulting in death) a. Liver Cirrhosis Due to (or as a consequence of): Acute Renal Failure											
AGII		Sequentially list conditions,	b. A cu			al to	ailune	-		+			
and -transit	xaminer	Cause (Disease or linjury	c		If any reading to manediate Due to (or as a consequence of; cause. Enter Underlying Cause, (Disease or linjury								
	ļΨ	resulting in death) Last Due to (or as a consequence oi).								_			
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tending physician ir use as the burial	ian/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d23c. If yes, outcome c	of pregnancy	eath 3 🗆		у			rate of deliv			
the attending physician ched for use as the burial	nysician/Medica		d	of pregnancy	eath 3 🗌	Ectopic pregnanc Other (specify)	у			eate of delivionth	rery Day Year		
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has been signed by the attending physician age 2 should be detached for use as the burial	þ	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal de time of deat	eath 3 🗌 h 5 🗆	Other (specify)		1 🗆 24a. Was autor	obacco use cor Yes 2 No	atribute to t 3 Pro . Were auto	he cause of death? bably 4 Unknown psy findings available mpletion of cause of		
tificate has been signed by the attending physician ior, page 2 should be detached for use as the burial	e Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal de time of deat	eath 3 🗌 h 5 🗆	Other (specify)	ren in Part I.	1 ☐ 24a. Was autor perfo	obacco use cor Yes 2 No an 24b	ntribute to t 3 Pro . Were auto	he cause of death? bably 4 Unknown psy findings available mpletion of cause of		
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State Registrar

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHAWAJA FAROOD, 2001 Medical Parkway, Annapolis, MD 21401

31. Date filed (Month Day Year) 7 2011 32. Registrar's Signature & Sansar

11-07413 Maricus Kyle Perkins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

ilicus Nyle Pe	,,,,,,,,,	1- For State	ertificate of			g. No.		
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Deat	h	3. Time of Death	
edical Exami	iner	Maricus Kyle Perkins			Month October 3,		1426 hrs	
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Baltimore	Death	4c. County of Deat	th	
·		University Hospital 5. Social Security Number 6. Sex 7. Age (In yrs.	last hirthday)	If Under 1 Year If Under	24Hrs 8 Date of Birt	h (MM/DD/YYYY) 9. Bi	irthplace (State or	
Funeral Director		217-31-0911 1XM 2_F	20 Yrs	Months Days Hours	Min. Jan 6	Forei		
any		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Locat	ion			10d. Inside City Limits	
* .	F	Maryland Anne Arundel (Odentor	n			1 Yes 2 No	
Maryla 28a-f d at oi	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	untry?	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	i Di	206 Goldsborough Dr.	La Lac Ma	21113	0/0	USA 14. Race - American Indian, Black,		
ath wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		as Decedent of Hispanic Origin es, specify Cuban, Mexican, F		White, etc.	rican Indian, Black,	
fter de 1", or	by Fu	1 Yes 2 X No 3 Widowed 4 Divorced or Dates:	1	Yes 2 X No specify:		Specify: B1	lack	
ours a latura xamiu	g p	15. Decedent's Education (Specify only highest grade completed)		nt's Usual Occupation (Give kings)		16b. Kind of Business	/Industry	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fleat and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed	College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)		employed	,	N/A		
21215-0036 21215-0036 buld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Con	17. Father's Name (First, Middle, Last)	<u> </u>		Name (First, Middle, M			
121 I be fil ental F arked	Be	Johnnie M. Perkins		The same of the sa	Lomo M. G			
MD 2 Id 2 should the and M m 27 is m aumatic	ဥ	19a. Informant's Name/Relationship (Type, Print) Kikelomo M. Gray (Mother)		g Address (Street and Numb Goldsborougl		enton, Mo		
e, N and 2 Health item 2		20a. Method of Disposition 20b.	1	pition (Name of cemetery, her place)	Date	20c. Location - City o		
Baltimore, permit. Pages I an Department of Hea Important: If iter		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	emoria	1 Gardens	10-10-11	Annapo:	lis, Md.	
altir mit. F partme porta ury or		21. Signature of Funeral Service Licensee	2 2 W	hame ampled dress of Facility	Sons Mort	uary, P.	Α.	
E R G B M		Larry M. Reese	1	922 Forest	Dr. Annap	olis, Md	. 21401	
Physician Medical		23a. Part I. Efter the disease, or complications that caused the death failure. List only one cause on each line.			diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) of Due to (or as a consequence of Due		Left Thigh			Deam	
		Sequentially list conditions, b.						
	iner	if any, leading to immediate Due to (or as a consequence cause. Enter Unidenying Cause	of):					
d sit	хаш	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conseq	of):	-	· <u> </u>			
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	Medical Examiner	d amended						
60, ate be e hysician e burial	ledic	IF FEMALE: 23c. If yes, outcome of pres	gnancy			23d. Date of delive	DV.	
6876 ertifica fing ph		23b. Was decedent pregnant in the past 12 months?	2 Fe	etal death 3 Ectopic p	pregnancy		Day Year	
Box 687 death certific the attending p	Physician/I	4 Pregnant at time of do	eath 5 Ot	ther (Specify)		ľ		
O. Entire d		Part II. Other significant conditions contributing to death but not	resulting in the t	underlying cause given in Part	I. 23e. Did to	bacco use contribute to	the cause of death?	
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Physicar this eral direction	ျ	1 Yes 2 No Inpatient 2 Yes 27. Manner of Death 28a. Date of Injury	ER/Outpatient		•	Residence 6 Othe	er:	
	tion	1 Natural 5 Pending Oct 3, 2011, Year)	1348 hrs	1 Yes 2 ✔ N	Subject shot			
Division of To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director. To the Funeral Director.	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At h	nome, farm, stre	et, factory, office building, etc.	28f. Location (S or Town, S		tural Route Number, City	
Dital ours a filled	Cert	4 Homicide determined (Specify) Local Stre			900 Herndon	Court, Baltimore , M		
he Ho in 24 h he Fur	ical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination a	dge, death occur and/or investiga	rred at the time, date and plac tion, in my opinion, death occ	e, and due to the causured at the time, date a	e(s) and manner as sta and place, and due to t	ated. the cause(s)	
To t To t	Medical Certification:	and manner stated. 29b. Signature and title of certifier		29c. License number		29d. Date signed (M		
		delin Broull ME		O.C.M.E.		October 4, 2011	1	
12		30. Name and address of person who completed cause of death (Iter						
X2.		Melissa Brassell, MD Assistant Medical Exami			Itimore, MD 2122	3		
S	tate	31. Date filed (Month, Day, Year) OCT 07 2011 32. Registrar's Signat	LITE A	ares				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34205 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Elizabeth Laura Meade Proctor Medical October 07, 2011 1645 p 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director Days Min 1 □ M 2 🕇 F 229-28-1617 Yrs 88 Usual Residence of Dec 7-3-1923 Richmond, VA ms 23a or 28a-f show must be notified at death with the Maryland Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Rockville 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 4208 Landgreen Street 20853 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 3altimore, Maryland 21215-0036 filed within 72 hours after 1 Never Married 2 Married Black, White, etc. Completed 1 Tes 2 No Specify: Specify: Year or Dates **Black** Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Management Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental Hant: If item 27 is marked of 0 Harvey Meade Jeanette Hailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauren E. Proctor/ Daughter item 2 4208 Landgreen St. Rockville, M.D. 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Parklawn Cemetery 10/17/2011 | Rockville, M.D. 21. Signature of Funeral Service ic 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, M.D. KI 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Physician/ disease or condition resulting in death) Bilateral Pneumonia 2 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Bilateral Pleural Effusions Examiner 2 weeks Due to (or as a consequence of) and COPD years physician a the burialresulting in death) Last Due to (or as a consequence of): Physician/Medical as t IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant for in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by 23e. Did tobacco use contribute to the cause of death? Vascular Dementia, Chronic Kidney Disease 2[★] No 3 Probably 4 Unknown has 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an autops, performed? autopsy 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of

Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 Records, Division of Vital

s after death. the

within 24 hours after To the Funeral Direc

State

Supanech Rom Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Pay, OCT 1 3 2011

5 Pending

Investigation

determined

6 Could not be

Natural

Accident

Suicide

4 Homicide

only one)

29a. Certifier

D 0065485

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at

work

1 Yes 2 No

29d. Date signed (Month, Day, Year) 201

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Barbara Supanich RSM, M.D. 1500 Forest Glen Rd. Silver Spring, M.D. 20910 32. Registrar's Signature

Registrar

injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

11-07503 Kevin D. Perry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011

		1- For State Registrar Amend#4a_PerMFO_PGC10-17-11cr Certificate of Death	F	Reg. No.					
Physiciar Medical Examin	W	i. Decedent's Halle (Flist, Middle, Last)	2. Date of De Month October (Day Year	3. Time of Death 1815 hrs				
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De 8810 Breadford Silver Spring	ath	4c. County of De Montgomer					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	47.	irth(MM/DD/YYYY) 9.	Birthplace (State or reign London, Country) England				
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
Maryland 28a-f show	ģ	Maryland Montgomery Silver Spring	<u> </u>		1 X Yes 2 No				
ith the Maryland 23a or 28a-f sho audified at once	Dire	10e. Street and Number 8810 Bradford Road, Apartment #3 20901		10g. Citizen of What C USA	ountry?				
r death w	Fune	11. Marital Status 1		0- 14. Race - Ar White, etc Specify: WI					
ours af	<u>۾</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of the completed)		16b. Kind of Busine	ss/Industry				
21215-0036 Id be filed within 72 hours after dental Hygiene. event, the Medical Examiner Deference of the Control of the Contr	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunications En		CADD Syst	tems				
21215-0036 uld be filed within 7 Mental Hygiene, marked other than e event, the Medica	ပေျ		me (First, Middle, cia A. Ve	Maiden Surname)					
212 Ould be Menta mark	80	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			ate, Zip Code)				
MD d 2 sho lith and n 27 is	1	Patricia J. Perry-Burgess / Sister 8212 Flower Ave., #20							
Baltimore, MD 21215 permit. Pages I and 2 should be filed Department of Health and Mernal Hy Important: If item 27 is marked of injury or other traumatic event, in		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 10	Date /12/2011	20c. Location - City Alexandri	or Town, State a, Virginia				
Balt permit. Departi Import injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral H	ome, P.A.	4739 Balt Hyattsvil	imore Avenue le, MD 20781				
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial failure. List only one cause on each line.	c or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death				
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Deau				
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		 .					
ted nisit		cause. Enter Underlying Cause (Disease or injury that initiated c.							
xecuted a and - transit		events resulting in death) Last Due to (or as a consequence of): d.							
ं तत्त्व .	ge	UNPENDED AMENDED							
8760, ifficate be up physici		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	inancy	23d. Date of deliv	very Day Year				
Box 68' e death certification the attending ed for use as by et class.	Physician	past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 1 Other (Specify)							
P.O. rres that the signed by the detached	6	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism			to the cause of death?				
Records, The law require, ficate has been sig	Detel		24a. Was		autopsy findings available to completion of cause of				
Reco	Ē			ormed? death	?				
tal Recitan: The certificate rector, pay	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nur.							
of Vital ing Physician After this certi uneral directo	2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Residence 6 Ot	her: Scene				
lon (lending sath.		1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 1 Yes 2 No							
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certif the Funeral Director. After this certificate has been signed by the attending tipletely filled in by the funeral director, page 2 should be detached for use as lital Certification: To Re Commissed by Dhusirian		2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (or Town, 5		Rural Route Number, City				
To the Host within 24 hc To the Fun completely Medical C		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.							
To with To com		29b. Signature and title of certifier 29c. License number		29d. Date signed ()					
		0.C.M.E.		October 7, 201	1				
		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Balt	imore, MD 21	223					
State	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Octobe 1820M Chester Allen RAGLAND, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown <u>Meritus Medical Center</u> Date of but (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Hours ^{Year)} 1957 Maryland Director Oct. 54 219-66**-**0636 Usual Residence of Decedent Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21740 11006 Coventry Lane 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Mechanic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Shirley Ann Myers Robert Eugene Ragland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11006 Coventry Lane, Hagerstown, Maryland 21740 Jenny Ragland - wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland Rose Hill Cemetery | 10/15/2011 Mame and Address of Facility Minnich Funeral Home 21. Signature of Euneral Service Licenses E. Wilson Blvd. Hagerstown, Md. 21740 Approximate Interval Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician MyoCARDIAL HCU76 INFANCTION Hn disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown detached tor: After this certificate has been signed by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury Investigation Accident 24 hours after deatl Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DO051395 October 13, 2011

State Registrar 30. Name and address of person who completed ca

2011

11110 MEDIUR CAMPUS RO. SUITE

mo 2174

ise of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9 Reyes Zoila 23:39 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10th Place 6005 Hyattsville Prince If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 578-08-7477 **Director** 1 M 2 F 63 4-16-1948 El Salvador 28a-f show 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Hyattsville 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 20782 U.S. 6005 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. and Mental Hygiene. is marked other than "natural", or þ 1 Never Married 2 Married 1 Yes 2 No Specify: Salvadorean Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-employe 3rd 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is .daughte enndale 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 📜 Burial 2 🗆 Cremation 3 🗀 Removal from State George Washington 10-8-11 Adelphi 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. H. Bacon Funeral Home 14th St. NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer Olon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) in and that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the buri Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Vear signed by the at I be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 🗶 No 1 🗌 Yes _ Yes To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? X Natural injury 5 Pending 2 No the f Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be completely filled in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) 10/10/11 22125 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKHILE MD 20852 4701 Randolph Rd #216 Mendo 20 GINO 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34209 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ochober 9Day 2011Year 1:00 A M Fernando Antonio Rivero Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15220 Open Land Court Dayton Howard Social Security Number 8. Date of Birth (Month, Day, Ye Sept. 17, If Under 7. Age (In vrs. last birthday) **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Hours Dominican Repub **Director** 578-70-5285 195160 Usual Residence of Decedent show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD Howard Dayton 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 15220 Open Land Court 21036 USA items 2 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 1 [™] Yes 2 □ No Specify: Dominican White If Yes, Give Year or Dates and Mental Hygiene. is marked other than "natural", Completed 3 Widowed 4 Divorced Specify. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Janitorial Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve once. ပ Rafael Rivero Alicia Hernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine E. Rivero/Wife 15220 Open Land Court, Dayton, MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 1 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Signature of Eugeral Service Licenses uan Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Esophageal Cancer disease or condition vr Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Dav Year Pregnant at time of death Yes 2 No detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 X No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 🔲 Yes 2 🗆 🖎 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 \square Pending injury work? 1 🔲 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 October 10, 2011 0063083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar M. Naomi Horiba, MD

12

2011

31. Date filed (Month, Day, Year)

OCT

backer

22 S. Greene Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10-09-201 John W. Richards 10:22 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Envoy Nursing Home Caroline Denton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min. 6/22/1921 90 Director 219-14-5947 Pennsylvania Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location Director 1 X Yes 2 No MD Caroline Denton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 Colonial Drive 21629 USA 12. Was Decedent Ever in U.S. Armed Forces? 1

→ Yes 2

No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any Injury or other terms. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Banking 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Alton Richards Ruth Brandt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine P. Richards, Wife 410 Colonial Drive, Denton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State Chesapeake Cremation 10/10/2011 Stevensville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Fellows, Helfenbein & Newnam Funeral Home, P.A. 21601 200 South Harrison Street, Easton, MD SHOW M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final aspiration Pnysician/ disease or condition Incumoric Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

The birth 2 Fetal death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Unursing Home 5 Residence 6 Other (Specify) After this 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

within 2 To the 1

G+VA State Registrar

2 rotgo 31. Date filed (Month, Day, Year) 1 2011

29b. Signature and title of certifier

egistrar's Signature

29c. License number

2002352

RZ

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. dent's Name (First, Middle, Last) 2. Date of Deleth Physician/ Menth 235PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
Anne Arundel Severna Park 520 Bayberry Drive Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Month, Day, Year)

July 28,1940 Days 1 ☑ M 2 ☐ F Months Hours 394-38-4937 Director Yrs Wisconsin Usual Residence of Decedent 28a-f show ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 🗌 Yes 2 🔀 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 520 Bayberry Drive 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give White 1 Yes 2 X No Specify: 27 is marked other than "natural", traumatic event, the Medical Exal 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
27 is marked other than ' College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Banking Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leonard Raddatz Dolores Eilers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Bayberry Drive Severna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) Joyce Raddatz / Wife and 2 s Health a permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 11 1 Durial 2 XCremation 3 Removal from State Metro Crematory, Baltimore, MD INC 2011 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 P.A. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 1-11 rules and one cause on each line. Approximate Interval Between Immediate Cause (Final et an Deat Physician/ disease or condition resulting in death) Medical e to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a surresqueries of): cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Completed 2 🗌 No 3 Probably 4 Donknown 1 Tes has been si e 2 should b 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law autopsy performed prior to completion of cause of death? page this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina death. n 24 hours after death. e Funeral Director: A bleted filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Maintal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F only one) ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sign: 18

Box 68760

P.O.

Division

State Registrar

DEFENSE HWY, ANNAPOLIS, MDZIGOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 342 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / G Physician/ CEI (2020 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 523-62-6170 Days Hours **Director** 1 M 2 F 62 Feb. 07,1949 Japan Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified MD Anne Arundel Arnold 1 🗆 Yes 2 🙀 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 411 Golf Course Drive 21012 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Force ō 1 ☐ Yes 2 X No If Yes, Give Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 X Divorced Completed Specify Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Owner Crafts Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ျ Robert M. Hamilton Janet Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Christine Coulson / Daughter 416 Calvert Road Stevensville, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory, INC. Baltimore, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final) Physician/ disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examin ENOOCARDITIS or Attending Physician: The law requires that the death certificate be executed TOTERIAL and burial-trar resulting in death) Last physician Physician/Medical lar Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day 1 L Yes 2 No 9 Unknown Pregnant at time of death Month Year signed by the ar Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed' Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 욘 1 Yes After this Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work s after death. Accident Investigation М 1 Tes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ed cause of death (Item Name and address of person 23a) (Type, Print) E strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34213 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month/O 3. Time of Death Physician/ 3:51PM Randal Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical Center mundel me Anundel Mappilis Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Aug 99, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Days Min. 212-46-7052 68 1943 Maryland Director Usual Residence of Decedent shov th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2X No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 130 Hearne Rd. Apt 1106 21401 USA 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ ☐ Yes 2 🏋 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3X Widowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Nurse permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other I any injury or other traumatic event, th Home Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Powell Hester Creek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hester L. Makell(Sister) 6125 McKendree Rd. Dunkirk, Md. 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 4 Donation 5 Other (Specify) 10-10-11 Baltimore, Md. 21. Signature of Funeral Service Licensee Mmame Research ScilltSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. Lavr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hone disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -trar Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Dav Pregnant at time of death Unknown ed by the a g 🗌 Unknown signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 ☐ Yes 2 ☑ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 🗌 Yes မ 1 🖾 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural s after decal al Director: Afte work? 1 Yes 2 No 5 \square Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Date signed (Month, Day, Year)

State

Registrar

Rebecca

31. Date filed (Month, Day, Year)

Parkway

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2001 Medical

32. Registrar's Signature

Buch

OCT 07 2011

72036

Annapolis

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TO/12/2011 3:55 Α Lynn Wayne Richards Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Northampton Manor Frederick Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ F Months Days Hours Callittornia **Director** 362-56-4795 59 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 XNo MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Jnited States 200 East 16th Street 21701 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 📈 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event. the Mex Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Project Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Onalee Elaine Day Ronald Duane Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Debra McCarthy/Sister</u> Oriole Ct., Shepherdstown, WV 25443 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 10/17/2011Falling Waters WV Harmony Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Jefferson Chapel Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. (reld) Town, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final DEMENTIA Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. ter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the sahould be detached ☐ Yes ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: မ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29d. Date signed (Month, Day, Year)

35m

Registrar

Date filed (Month)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAYE ENBOLANUM MD 1967 JULIE, PLEDEMIE, MD 21702

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 34215 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3, 2011 October 9:06 A M Annunziata Scarano Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 06/13/1931 Italy 579-62-9800 Director 80 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits with the Maryland **Funeral Director** DC Washington 1 X Yes 2 ☐ No 10f. Zip Code 20015 10a. Citizen of What Country? 3335 Military Road NW / Italy death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. or other traumatic event, the Medical Examiner 5 Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 21215-0036 within 72 hours after 1 Yes 2 XNo Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6 Catering Food Service Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked o ၉ Francesco Verrengia Orsola Festa permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pio Scarano / Son 10210 Big Rock Rd. Silver Spring, MD 20901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Gate of Heaven Cemet. 10/06/2011 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility Joseph Gawler's Sons Inc. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5130 Wisconsin Ave. NW Washington, DC 20016 interval Between Immediate Cause (Final disease or condition Onset and Death critical ovortic Stenosis Ph si∟ian Medical resulting in death) Examiner coronary av Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ fibrillation atrial Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 💆 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Completed filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0064413 MI cause of death (Item 23a) (Type, Print) Name and address of person who completed Juanity Smith, MD Medical Center Drive, Rockville, Maryland 20850 9901 31. Date filed (Month, Day, Year)

OCT 12 2011 State

Registrar

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SCARANO

		State Registrar		Ce	ertificate of	Death	F	leg. No. 2	111	3421
		1. Decedent's Name (First, Middle,	ast)				2. Date of Dea Month	th Day	Year 3.	Time of Death
Physi /Med		Jeet Inderpal	Singh				October		11 9	9:40a M
Exam		4a. Facility Name (If not institution, §	ive street and number)		4b. City, Town, o	r Location of Deat	h	4c. County	of Death	
		8577 Indian Spri				lerick			rederio	
Funera		,	. Sex	(In yrs. last birthda)	Months Days	If Under 24 Hrs Hours Min.	(Month, Day	Year)	Country)	(State or Foreign
Directo	or	217-49-5393 Usual Residence of Decedent		78 Yrs.			Sept.23	3, 1933	Ind	ia
land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. i	Inside City Limits
Marylan -f show	to	Maryland Frede	rick	Frederio	12				1	1 □Yes 21X No
r 28a	Director	10e. Street and Number	LICK	riedelic	10f. Zip Code			10g. Citizen of V	What Country?	
3a o			irt Ant. 3	R	21	702		United	States	S
death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		. Was Decedent of H	lispanic Origin? (S	Specify Yes or No-	14. Rac	e - American Ir	
after or ite				lo	1 ☐ Yes 2X No	Specify:	to Ricari, etc.)	Specify	ck, White, etc. ./· Asiat	n
ours ural",	d b		Year or Dates:						· .	
ifiled within 72 hours after death with the Maryland Hygiene. Hygiene, The "natural", or items 23a or 28a-f show ent, the Mydical Evanther must be rectified at	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dec	edent's Usual Occup e kind of work done o DO NOT use retired	pation during most of wo	rking	16b. Kind of Bi	usiness/Industr	У
within sne.	E	Elementary/Secondary (0-12)	College (1-4or 5-	+) IIIe.				0	TT	
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should be mark	၉	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street			r. Citv or Town.	State. Zip Coc	de)
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s 1 a		20a. Method of Disposition	<u> </u>		osition (Name of ematory or other place		Date	20c. Location -		
Definition of the state of the Maryla programs after death with the Maryla Department of Health and Mental Hygiene Department of Health and Mental Hygiene Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine Trust be neithed at		1 ☐ Burial 2 【X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			Cremator	· · · · · · · · · · · · · · · · · · ·	/11/11	Frederi	ck. Mar	cvland.
mit.	ej l	21. Signature of Funeral Service Lic					/ D	1	CR, Hai	. y zana i
a a E E	ouce	2001116	2/1/ins		22. Name and Addre Stauffer F 621 Oposs	uneral E umtown P	ike, Fre	derick,	Marylar	nd 21702
		23a. Part 1. Enter the disease, or co shock, or heart failure. List on		the death. Do not e	nter the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	App	proximate erval Between
Physician	n	Immediate Cause (Final disease or condition	Hen	extic. F	Failur	re			Ons	set and Death
/Medica	1	resulting in death)	Due to (or as	a consequence of):			/ / /			77000
Examine		Sequentially list conditions	b. Nei	e. WHC F a consequence of): 1 YO EN do a consequence of):	crine	Tumo	of the	e Live	V / L	1ear
et ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of):			U		/	
ecute and -trans	Kam	Cause (Disease or injury that initiated events resulting in death) Last	C	200000000000000000000000000000000000000						
be ey ician ourial			Due to (or as a	a consequence of):						
certificate be executed ding physician and se as the burial-transit	Medical		d							
ertif Ing			23c. if yes, outcome	of pregnancy				22d Da	te of delivery	
at the death c by the attend tached for us	Physician	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	у			onth Day	y Year
the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown							
ge a	by Pt	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use con	ribute to the ca	ause of death?
quires in sign							1 □ Y	es 2 No	3 Probably	y 4 ☐ Unknowr
law requir as been s 2 should	Completed						24a. Was a		Were autopsy	findings available
The lacate ha	E E						autop perfor	med?	prior to comple death? 1 ☐ Yes 2 ☐	etion of cause of
lclan: certifica ector, p	Be C	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only or		TILL TES ZI	1110
nyslcian: nis certific director,	면 면	examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatio	ent 3 DOA Oth	ier: 4 🗆 Nursing I	Home 5 Resid	lence 6 🏝 Oth	ner (Specify)	aughters Home
Attending Physician: r death. ector: After this certifica by the funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y 28b. Time (Year) injury		ry at k?	28d. Describe h	ow injury occur	red	
endii eath. or: A he fu	ätic	2 ☐ Accident investigat	ion			Yes 2 □ No				
l or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not determine	28e. Place of Inju- building, etc	rry - At home, farm, s . <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Tow	Street and Numb n, State)	er or Rural Ro	oute Number,
ital curs af										
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical		Physician: To the best of aminer: On the basis of	examination and/or						
thin 2 the omple	Med	29b. Signature and title of certifier	and manner sta	tea.	29c. Licens	se number		29d. Date signe	d (Month, Day	Year)
F 3 F 8			1	~	7	4,8		ctob.		
		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type	Print)	, , , L	udhud	A	2	
9	-	46B Thomas				700	Frod	leng k	i, min	21702
s	tate	31. Date filed (Month, Day, Year)		r's Signature	land 1				- 1 111	
Regis	trar	OULTE	LUII CONSES	Mr. 19. 19	The Contract of the Contract o					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) FRANCES HELEN SANDS 2. Date of Death 3. Time of Death Physician/ OCTOBER 4Day 2011Year SANDS-1:45P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕇 Days Hours 02/13/1930 Director 573-46-6649 81 Yrs. Usual Residence of Decedent 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location event, the Medical Examiner must be notified at Funeral Director 10d. Inside City Limits 1 Tes 2 No Frederick Thurmont ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 7 Westview Court 21788 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 0 ò 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates. "natural", 3 Midowed 4 Divorced Completed Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) contract administrator construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Latham Frances Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. <u>Ann Sands/daughter</u> Westview Court, Thurmont, MD 21788 20a. Method of Disposition
1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 10/08/2011 Frederick, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 00 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as carding or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 20hrer MD Physician/ Onset and Death disease or condition resulting in death) Pelvic fracture Medical **Examiner** fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi). Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery signed by the atte d be detached for Month Day 1 ☐ Yes 2 D g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Cardiogenic shock, congestive heart failure Completed page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an coagulopathy, COPD autopsy performed? Yes 2 X No After this certificate 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 No မ Other: 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred partient 105t boucence and ☐ Natural Accident 5 Pending injury Certifical work? 1 ☐ Yes 2 🔀 No within 24 hours after death.

To the Funeral Director: A: completed filled in by the fu Noon 10/01/11 Investigation fell Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5449 Urbana PK. Frederick, MD Restaurant Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier title of gertifier 29b. Signature an 29c. License number signed (Month, Dav. Year) MOD 65378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Agarunov 7th St Frederick, MD 400 w 31. Date filed (Month. Day, Year) State Registrar's Signatur Registrar

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hristian Hamilt	on S	1- For State Registrar	tate of Maryla	-	artment of rtificate of		Mental F		2 0 eg. No.	11 3421
Physicia Medical Exami		1. Decedent's Name (First, Mide						2. Date of Dea Month October 1	ith	3. Time of Death 1352 hrs
		Christian Hai 4a. Facility Name (if not instituti			1.	4b. City, Town, or Lo	ocation of Deat		5, 2011 4c. County of Dea	
		13050 Hillmeade Cou				Charlotte Hal	II .		Charles	
Funeral Director		5. Social Security Number 220–17–3797	6. Sex 1∑XM 2 F	7. Age (In yrs. I 35	• •	If Under 1 Year Months Days	If Under 24Hr Hours Min		rth(MM/DD/YYYY) 9. B	
any		Usual Residence of Decedent 10a. State 10b. County		Idoa Citu	Town or Locati		<u> </u>			
*	L	,	rles	Toc. City,	Town or Locati	∘⊓ Charlott	e Hall			10d. Inside City Limits 1 Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	
h the N 23a or		13050 Hillmead	de Court			2062	22		United St	tates
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Funeral	11. Marital Status 1 XX Never Married 2 N				s Decedent of Hispa es, specify Cuban, I			14. Race - Ame White, etc.	erican Indian, Black,
ufter de	by Fu	3 Widowed 4 Di	1 Yes vorced If Yes, Give Year	2}(∑) No	1	Yes 2 No	specify:		Specify: Wi	nite
hours a		15. Decedent's Education (Spe				t's Usual Occupation ost of working life. D			16b. Kind of Business	/Industry
36 thin 72 than "	ompleted	Elementary/Secondary (0-12)	College (1-	4 or 5+)		arpenter		,	Constr	ruction
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ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medica	o Be	Kevin J	Egan Sween	<u></u>	19h Mailing	Address /Street		_	nn Queen nber, City or Town, Stat	75 0040
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Baltimore, MC permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other traum.		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal fro			tion (Name of ceme		Date	20c. Location - City o	
Baltimore, permit. Pages I an Department of Her Important: If ite		4 Donation 5 Other S	gecify:	Me		ematory				e, Maryland
Bal permi Depar Impo	(21. Signature of Funeral Service	A Icensee	D					eral Home , MD 20715	
Physician	┪	28a Part I. Enter the disease, or failure. List only one cause	complications that ca	used the death.						Approximate Interval Between Onset and
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760, cate be ex physician he burial		IF FEMALE:	23c. If yes, or	utcome of pregr		70			23d. Date of deliver	у
x 6876(h certificate tending phys	cian/	23b. Was decedent pregnant in the past 12 months?	I Live bit	th nt at time of dea	ath -		Ectopic pregna	ancy	Month	Day Year
Bo e deat the at	Physician/M		known 9 Unknov			er (Specify)				
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rds, requires	eted							24a. Was a	an 24b. Were a	utopsy findings available
ecor he law tte has b	Completed			1				autops perform 1 V Yes 2	med? death?	completion of cause of
Division of Vital Records, tal or Attending Physician: The law requir is after death. Al Director: After this certificate has been is led in by the funeral director, page 2 should be	Be C	25. Was case referred to medica examiner?					Death (Check		2 No 1 Y	es 2 No
f Vit	욘	1 ✓ Yes 2 No 27. Manner of Death			ER/Outpatient				Residence 6 🗸 Othe	r: Scene
on of anding Phonth.	Certification:	1 Natural 5 Pend	28a. Date o (Month, I	Day,Year)	28b. Time of In	1 Vos	at vvork? 3. 2 🛣 No	unknown	ow injury occurred	
ViSicor Atta	ifica	. \square	sugation			, factory, office build		28f. Location (S	treet and Number or Ru	ural Route Number, City
Divis the Hospital or A hin 24 hours after the Funeral Direct upletely filled in b	등	4 Homicide deter	mined (Specify)		at hon			Compton,		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only Certifying Pi		examination an					e(s) and manner as statend place, and due to the	
	Ž	29b. Signature and title of certifie	1	1./		29c. License n			29d. Date signed (Mo	
	L	30. Name and address of person	who completed cause	of death (Item	23a)	U.C.IVI.	L .		October 16, 201	
		Jack Titus MD. Dep	uty Chief Medica			altimore Street	, Baltimore,	MD 21223		
Sta Registi	ite rar	31. Date filed (Month, Day, Year) $0CT21$		strar's Signatur	1 1	Kal	·			
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Baltimore, Maryland 21215-0036

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	Medic Examir	cal	Raymo 4a. Facility Name (#	not institution	llan		IISKI		4h City	Town or	Location of Dea	Month		County of	Dooth	11.587 M
-	LAGIIII	ici	Bottomo	PE WI	ASHIMI	Grone		DILALC	ENTE	2	CLEN	BURN		Ann		ARUNIBE
	Funeral Director		5. Social Security N 218–54–3		6. Sex 1 🔀 M :	7. Aç	ge (In yrs. I 61	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hr Hours Mir		irth ay, Year) Q. 1Q!	50	9. Birthpi Count Mary	ace (State or Foreign
	nd how at	٦	Usual Residence of 10a. State	Decedent 10b. County			10c. Cit	y, Town or Lo	cation			1144	7,17.			0d. Inside City Limits
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	/ith the 23a or st be n	Funeral Director	10e. Street and Nur 925 Rye		Court				10f. Zip	Code 2114	6	· · · · · · · · · · · · · · · · · · ·	_	itizen of Wh	at Count	ry?
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Marr	ied 2 X Mar	ried 1	'as Decedent rmed Forces? Yes 2 X Yes, Give		1		lent of His	spanic Origin? (\$ n, Mexican, Pue	Specify Yes or No to Rican, etc.)		14. Race -	White, e	
5-00	2 hours "natura dical E	plete			nt's Educatio			16a. Deced			ation uring most of we	orkina	16b. K	Kind of Busi	ness Ind	ustry
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09289	ath certificate be attending physici for use as the bu	/Med	IF FEMALE:		T		,									
). Box (Physician: The law requires that the death certificate be this certificate has been signed by the attending physicial director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	1 4	yes, outcome Live Birth Pregnant a Unknown	2 Feta	al death 3 🗌	Ectopic p	ecify)				23d. Date (Month		y Day Year
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/ital	sician: The la certificate ha irector, page 2	Be	25. Was case referre examiner? 1 Yes 2	d to medical	Hospita	al:				100	ce of Death (Che					
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Division	If or Attending after death. Director: After d in by the fune	Certificate:	2 Accident 3 Suicide	Investig	gation not be			me, farm, stre	M et factory	1 🗆 ነ	∕es 2 □ No	28f. Location (Stroot an	d Number o	er Dural E	Pauto Number
Divi	tal or tres after al Dire		4 Homicide	determ	illed	building, etc	c. (Specify,)				City or To	wn, State))		
	To the Hospital or v within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2	Medical E	xaminer: On	the basis of e	xaminatior	n and/or invest	gation, in m	ny opinior	 death occurred 	and due to the ca at the time, date lace, and due to the	and place	 and due to 	the caus	e(s) and manner stated.
	To the comp	2	29b. Signature and	certifier	Nurse Plac	noner, to the			\neg							
			30. Name and addre	ess of person	who complet	ed cause of d	eath (Item		rint)	<u></u>	731	17		ovse	✓ Y	20161
(H30		31. Date filed (Month	Day Year	0 2	DI H	ecp.	itzel	رك ر	VIV	e 91	eu Bu	Write	e'm	<u>心</u>	20161
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34220 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Selma Streett 10:00 A M October 08 2011 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 98 Months Days Hours (Month, Day, Year) **Director** 217-07-5465 1 M 2 X F Sept. 13,1913 Maryland 28a-f shov 10b. County ms 23a or 28a-f sho must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Towson 1 ☐ Yes 2 X No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21204 1055 West Joppa Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten Examiner ı Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify. "natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Homemaker Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ပ္ Viola Greenwood Melvin Demmitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seaward Drive Severna Park, MD 21146 1 and 2 s of Health item 27 Mel Merritt/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 October Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC: 2011 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ concestive years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mont Month Day Year signed by ... detache 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 1 Yes 2: No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed 2 No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Locatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Contributing Nurse Practitioners To the best of my knowledge, death occurred at the films, date and, lack, and the names, and manner as state 29b. Signature and title of pertifier DO0 70 635 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) suite 4105 Baltimore, MD Pate N Charles St 701

State

Registrar

OCT 11 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#5,18 per FH State of Maryland / Department of Health and Mental Hygiene State Registrar AACO HEALTH DEPT. CMH 10/12/2011 Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1409 Bay Head Road Anne Arundel Annapolis 7. Age (In yrs. last birthday) 85 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Feb. 24, 1926 6. Sex **Funeral** 9. Birthplace (State or Foreign Country) Ohio 267-22-1074 287-22-1074 1 ☑M 2 □ F Months Days Hours **Director** Yrs 28a-f show 10b. County with the Maryland 10a, State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2XXNo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 1409 Bay Head Road 23a 21409 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mussonce. 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2XXNo Specify. White Completed 3 Divorced 4 Divorced 1944-46 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Psychologist Federal Government 5+ Be 17. Father's Name (First, Middle, Last) Stanley Solarz 18. Mother's Name (First, Middle, Maiden Surname) 2 Katherine Granski Grzonsko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1409 Bay Head Road Annapolis, Maryland 21409 Marilyn Solarz/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 10/21/2011 MD Veterans Cemetery Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility John M. Taylor Funeral Home かる 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rau, e on each line. Immediate Cause (Final TH eet and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Property of the action of the attending physicial physicials. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death
Unknown signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ been si should l Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has autopsy this certificate 1 ☐ Yes 2 ☐ No Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Tes ဂ Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) _0 6 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State istrar's Signature OCT 1 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death okes Physician/ October 2011 1891010 9:00 A M Medical la Facility Name (if not institution, give street and number) Heritage Harbour Health and Rehab 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 535–14–9184 **Funeral** Davs 90 Director 1 M 2XXF March 4, 1921 Washington show 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel notified 28a-f 1 Yes 2 X No ō 10e. Street and Numbe 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? 50 River Drive 21403 U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working th and Mental Hygiene. 27 is marked other than traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Sales Manager Jewelry Store Be Father's Name (First, Middle, Last)
Leo Lee Simpson 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Shaughnessy 19a. Informant's Name/Relationship (Type, Print)
William Stokes/husband 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 50 River Drive Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗌 Burial 2 🗶 Cremation 3 🗆 Removal from State Baltimore Crematory 10/10/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) unera **\$**ervy e Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 8 disease or condition Medical resulting in death) Due to (or as a consequence of Examiner ER TENSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit and Due to (or as a consequence of resulting in death) Last iding physician Physician/Medical P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) signed by the atter in the past 12 mont 4 Pregnant at time of death 9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director; After this certificate I 2 🗌 No 1 Yes Yes 2 filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗆 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manno Teath Certificate: 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 06-2011

State

SYED 31. Date filed (Mor

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State of Maryland / State of Maryland /	Department of Health and Certificate of Death	Mental Hygi	_	1 3422
	Physici Medi				2. Date of Death Month October		3. Time of Death 8:00 A M
	Exami	ner	5107 River Crescent Drive	4b. City, Town, or Location of Deat Annapolis		4c. County of Dea Anne	Arundel
*	Funeral Director		5. Social Security Number 239–36–4566 6. Sex 1 M 2 🗷 F 85 Usual Residence of Decedent	Yrs. If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Y Feb. 14	^(ear) 1926 No	rthplace (State or Foreign ountry) Orth Carolina
	Maryland 28a-f sho otified at	Funeral Director	10a. State Maryland 10b. County Anne Arundel 10c. City, Tov	Annapolis			10d. Inside City Limits 1 Yes 2 X No
	with the is 23a or	neral D	10e. Street and Number 5107 River Crescent Drive	10f. Zip Code 21401	10	g. Citizen of What Co U.S. A	ountry?
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerton 1 Yes 2 XXIII Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	thin 72 ho ane. than "na ae Medic	Somple	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired) Inspector	king	6b. Kind of Business. Health Der	,
Maryland 2	should be filed within and Mental Hygiene. is marked other than raumatic event, the M	To Be (17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma Callum		ar cheric
	id 2 should be salth and Ment n 27 is marke er traumatic e	1	19a Informant's Name/Relationship (Type, Print) Alice Gillis/daughter	p. Mailing Address (Street and Number or Ru 1924 Minnow Creek Roa	al Route Number, Ci ad Annapo	ity or Town, State, Zip Dlis, MD	21409
Baltimore,			20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	of Disposition (Name of ery, crematory or other place) rest Mem. Gardens 10,	Date 20	Oc. Location - City or	Town, State Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of uneral erry's Licenses	22. Name and Address of Facility Joh			
	Physician Medical Examiner	X 0	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	ivona of the lu		11.	Approximate Interval Between Onset and Death
00	te be executed iysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
). Box 68760	To the hospital of Artending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 modis? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
ls, P.O.	ures that n signed k uld be det	ed by P	Part II. Other significant conditions contributing to death but not resulting in the little type 2	n the underlying cause given in Part I.		co use contribute to	the cause of death?
Division of Vital Records,	The law req ate has bee page 2 shot	Somplet	Atrial Fibrillation.		24a. Was an autopsy performed	24b. Were aut prior to death?	opsy findings available completion of cause of
Vital	ysician: iis certific director,	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	26. Place of Death (Chec.	(only one)	e 6 Other (Speci	
on of	ending Preath.	Certificate:	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) in	inn of	28d. Describe how i		
Divisi	tal or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,
;	To the Hospital of Atte	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, only one) 1 ★ Certifying Physician: To the best of my knowledge, only one) 2 ★ Medical Examiner: On the best of my knowledge, only one)	r investigation, in my opinion, death occurred at	the time date and n	lace and due to the c	auga(c) and manner stated
	To t		29b. Signature and title of contifier	D-1F566	I .	Date signed (Month, $0 - 7 - 2$	
1	+20		30. Name and addings of person who completed cause of death (Item 23a) (The State of Adding Williams) 2629-Ri	VARd Suite 112	ANNAPOL		2140/
	State Registra		31. Date filed (Month, Day, Year) OCT 0 7 2011 32. Registrar's Signature	parker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shannahan 11000 Audrey Lee O ctober 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Wicomica Rehabilitation & Nursing Cto isbu Social Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Oct. 13, Year) 926 218-20-5935 Delaware 84 Director Usual Residence of Deceden 28a-f shov 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified DF. Sussex Laurel 1 Yes 2 X No o 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 30837 River Road 19956 USA Shannahas Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. ģ 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Ď 1 Never Married 2 Married 1 Yes 2 X No Specify: white "natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working oernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the waitress restaurant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George E. Townsend Ethel Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah S. Vincent daughter 30837 River Road, Laurel, DE 19956 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗋 Removal from State injury or Crematory of Delmarva 10/15/11 Delmar. DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. any in Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ladiovorcula Pnysician/ cers disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Eeve Sequentially list conditions, Examine Due to (dr as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the a d be detached for 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nhknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 N 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 유 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury_at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Nicholas

31. Date filed (Month, Dav. Year)

0

200 Civic Ave.

and address of person who completed cause of death (Item 23a) (Type, Print)

50 rodulia

welle

Salisbury

			Please 1	Type or Print in B			-	•	ole.
			for State	State of Maryland			nd Mental Hy	/giene	
			Registrar 1. Decedent's Name (First, Middle, Last,	·)	Certificate	e of Death	2. Date of De	Reg. No.	3. Time of Death
,	Physicia Medic		PhyLLIS IRE	NE Smith			Month / O		2011 1: 45 AM
Jacky.	Examin	er	4a. Facility Name (if not institution, give s AATO WASH, MED. 5. Social Security Number 6. Sex	CTR.	G	Fown, or Location of	NIE	4c. County of	ARUNDEL
ķ.	Funeral Director		214 56 1316 Usual Residence of Decedent	X 7. Age (In yrs. las	1 St birthday) If Under Months Months		Min. 8. Date of Bi	rth ay, Year) 2-49	9. Birthplace (State or Foreign Country)
	aryland a-f show fied at	Director	10a. State 10b. County	10c. City,	Town or Location	ocuille			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the M 3a or 28 it be noti	ral Dir	10e. Street and Number	ZODEC	10f. Zip	0 . 0		10g. Citizen of Wh	
	ems ?	Funeral	8329 NORWOOD 11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decede	2108 ent of Hispanic Origin	n? (Specify Yes or No-	14. Bace -	American Indian,
9000	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	5	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		fy Cuban, Mexican, F	Puerto Rican, etc.)		White, etc.
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Maryland 21	should and Me		19a. Informant's Name/Relationship (Typ		19b. Mailing Address ((Street and Number of	or Rural Route Number	er, City or Town, Stat	4 6
	e 1 and 2 s t of Health If item 27 or other tra		MELISSA SIMONS; 20a. Method of Disposition	DAURHTER 20b. Pla	S 27 AVE		OLEN BURN Date	20c. Location - Ci	2 (06 l
mo	a 0		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State Cer	metery, crematory or oth	her place)	-22-11	OVENTO	
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Juneral Service	2		Address of Facility		TY FUNE	ERAL HOME
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mone	Medical Examiner		disease or condition resulting in death)	Due to (or as a con Quei	nce of):	C 1 -			
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. Box 68760	ie death certificate be the attending physici shed for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 T No 9 ☐ Unknown	3c. If yes, outcome of pregnanc 1 ☐ Live Birth 2 ☐ Fetal o 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 🗌 Ectopic pr			23d. Date o Month	,
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n of	iding P th. After t funera	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	8b. Time of injury M	c. Injury at work? 1 ☐ Yes 2 ☐ N	1	how injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician; The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)					or Rural Route Number,
	Hospita 24 hours Funera eted fille	Medical	(Check 2 Medical Examine	cian: To the best of my knowled er: On the basis of examination a	and/or investigation, in m	y opinion, death occu	irred at the time, date a	and place, and due to	the cause(s) and manner stated.
	To the within To the Compli	Σ	only one) 3 ☐ Certifying Nurse 29b. Signature and title of certific	Practioner: To the best of my k		ed at the time, date ar License number	nd place, and due to the	ne cause(s) and mann 29d. Date signed (A	
	4		1012	- (3) M?	0 1	76572	6	10,18,8	1) 00
_	08h		30. Name and address of person who con	mpleted cause of death (Item 2:	3a) (Type, Print) K	ingre	waser	nelper	5 501Pl
	Stat Registra		31. Date filed (Month, Day, Year) OCT 26 2011	32. Registrar's Signatur	e arked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **JAMES** FREDERICK SCARLE JR. OCTOBER 2011 9:19 рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2 Manor Dr. Earleville Cecil If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**x** M 2 □ F Hours April Day 173-22-9438 1930 Pennsylvania Director 81 Usual Residence of Decedent show 10a. State 10b. County should be filed within 72 hours after death with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Cecil Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Manor Dr. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 No 1948 Completed by 1 Never Married 2 Married 1 XYes If Yes, Give Maryland 21215-0036 White 1 Yes 2 No Specify: 3 🗌 Widowed 4 🔲 Divorced -1952Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electrican Industrial 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked o any injury or other traumatic eve James Frederick Scarle, Sr. Matilda Thornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Scarle (wife) 2 Manor Dr. Earleville, MD. 21919 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Kent Cremation Services 10/20/11 4 Donation 5 Geber (Specify) Smyrna, DE. Tre of H ral Servic Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death lock, or hear failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate | 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 🛮 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of the 29d. Date signed (Month, Day, Year) D0062190 JM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2533 AUGUSTINE HORMAN HWY, SUITE A, CHESAPEAKE CITY KHAN SHAHNAWAZ Day, Year) 31. Date filed (Month. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tami Sue Souders Ktob Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Meritus Medical Center If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 6. Sex Age (In yrs, last birthday **Funeral** Penna. Days 204-40-2843 1 🗆 M 2 🛣 45 Min. Feb. Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Penna. Franklin Greencastle 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 17225 12350 Carol Ave. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Church Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ronald E. Walck Sharon M. Knepper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12350 Carol Ave. Greencastle, PA. 17225 Sharon M. Walck/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/19/11 Chambersburg, PA. Parklawns Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zimmerman And Son Funeral Home Signature of Funeral Service Licensee 45 S. Carlisle St. Greencastle, PA. 17225 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examin attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year the 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 3 Probably 4 Unknown 1 Yes Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 1 No Yes 2 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. Natural 5 Pending 1 \(\text{Yes} Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier e and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34228 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ THOMAS SCHEETZ Month OCTOBER 2011 10:37A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 X M 2 □ F Hours Country Maryland Aug. 7, 1954 57 212-62-4370 **Director** Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 💢 No Marvland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1304 New Design Road 21710 United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian þ Black, White, etc. 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: White Completed 3 Widowed 4 X Divorced Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Retail Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental I item 27 is marked o other traumatic eve ပ္ George William Scheetz Ethel Irene Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Scheetz / Son 7203 Drought Spring Drive, Frederick, MD 21702 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot October 22. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) St. Paul Cemetery 4 Donation 5 Other (Specify) Point Of Rocks, MD 2011 21. Signature f Funeral Service Licensee Keeney dadds Bastord PA Funeral Home, 106 E. Church Street. Frederick. 23a. Part 1. Enter the disease, or co shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) **Examiner** lyocan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physiclan and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery Live Birth 2 L recarded
Pregnant at time of death lo in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year sate has been signed by the page 2 should be detached 9 Unknown g 🗖 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Completed Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No After this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 00 မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation М 2 ☐ Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certit/ing Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Med/cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu

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State

Registrar DHMH 17 Rev 7/2009 n who completed cause of death (Item 23a) (Type, Print) 400

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36229 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 10:10P M Clifford Adam Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Hartley Hall Nursing Pocomoke City Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Days Hours Min 2 / 24 / 1915 96 73-07-7039 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b County 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Pocomoke City MD Worcester 10f. Zip Code ō 10e Street and Number 10g. Citizen of What Country? 23a Funeral 21851 USA 1006 Market St. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: white "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Reporter/Editor Communications other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Eva Wagner Frank Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Cedar Ave., Berlin, MD 21811 Mark Thomas / son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State State Crem. 10/12/11 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home ar William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final DEMENTIA Ph. sician/ 2 HEIMER' disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death signed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 → O 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? Yes 2 this certificate 1 Yes 2 No director. 25. Was case referred to medical 26. Place of Death (Check only one) æ Hospital Other: 2. No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director. After the completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10-10-2011 062172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604 MARKET ST. POCOMORE GTY MD 21851. SHARAD SATYAL, MU 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		5. Social Security N 579–90–9	789	6. Sex 1 □ M 2 🏝 F	7. Age (In yrs. 62	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8, Date of Bi	rth 2 49 ea <i>r)</i>		9. Birth	place (State or	Foreign
show at	ا ا	Usual Residence of 10a. State	10b. County	,	10c, Ci	ity, Town or Lo	ocation	_						1	10d. Inside City	y Limits
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>چ</u>	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed		Armed Fo	2. No e		Was Deceden If Yes, specify			in? (Spe Puerto	ecify Yes or No- Rican, etc.)	-		k. White.	ican Indian, , etc.	
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Physician/		shock, or hea Immediate Cause disease or condition	(Final	only one cause on ea	ch line.		acci	1	+						Interval Betw Onset and D	eath
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#15 per 15 per Shate of Maryland / Department of Health and Mental Hygiene 1 = State AMEND#26 per HIY AACO HEALTH 10/11/11/Centificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:20 A M STANLEY LEON TURNER SR. OCTOBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL 477 BROADNECK ROAD ANNAPOLIS Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 □ F **Funeral** Months Days Hours Min 0/19/1956 MARYLAND 214-66-2288 Yrs Director Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director items 23a or 28a-f s ner must be notified 1 Yes 2 X No MARYLAND ANNE ARUNDEL GALESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4677 MUDDY CREEK ROAD USA 20765 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Specify. Completed 3 Widowed 4 Noivorced BLACK permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CARPENTRY 12 CARPENTER Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HAROLD CHRISTERFIELD TURNER BESSIE MARIE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 58, GALESVILLE, MD 20765 VANESSA TURNER/EX WIFE altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State STGATE MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 10/17/2011 ANNAPOLIS, MD Signature of Funeral Service License Name and Address of Facility LASTING ELFENBEIN & NEWNAM CR HELFENBEINE&TREWN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ la disease or condition Medical resulting in death) Due to (or as a onsequence of): **Examiner** Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ned by the atten detached for u in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificants completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 \sum Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Dent Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifier D39505 any Hospital Dr. Glen Burnie, MD. 21061 Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 Markan 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34232 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Merle Month Year 233 A M lerenu 10 2011 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis 101 Speicher Dr. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Days Min July 6, 1934 579-48-3049 77 Yrs. Oklahoma **Director** Usual Residence of Decedent 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director notified 1 Yes 2 No MD Anne Arundel Annapolis ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be n Funeral USA 101 Speicher Dr. 21401 items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo and Mental Hygiene.
is marked other than "natural", or iten 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) P.G. County Schools 12 Office Manager traumatic event, Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gwyneth Tite Charles Oran Webber 19a. Informant's Name/Relationship (Type, Print) Department of Health are Important: If item 27 is any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Speicher Dr., Annapolis, MD Frank L. Terenyi / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State MD Veterans Cemetery 10/13/2011 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of meral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease shock, or heart failure. Li complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence 3) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 98 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2. No 1 Yes 2.5 9 Unknown the a Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 Yes 2 No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury after death.

Director: Aft
d in by the fur 2 Accident M Investigation n 24 hou.. the Funeral Dire. مما filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Pa), istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 4,2011 Bernard Guy Carroll Topper Jr. 8:53 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5336 Sweetwater Drive West River Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Months Days 192-36-4144 **Director** 1 XM 2 - F 64 11/24/1946 Maryland Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel West River 1 ☐ Yes 2X No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5336 Sweetwater Drive 20778 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give , or , þ 1 Never Married 2 Married 21215-0036 1 Yes 2xx No Specify: Specify: White "natural", Completed 3 Widowed 4XXDivorced Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Interior Budget Officer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Guy Carroll Topper, Sr. Elsie Langley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Bryan Companion 5336 Sweetwater DR. West River, MD 20778 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 10/6/2011 Glen Burnie, MD Crematory 21. Signature of Funeral Service icensee 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 48 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Erner Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 🗌 No Yes 2 Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes Other: မှ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital
within 24 hours a
To the Funeral C
completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier - Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 14+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Michael Riebman

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Monto CTYeV) 7 2011

Annapolis, MD 21401

129 Lubrano DR.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours a To the Funeral I

Myocandial	proporcha		1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy performed? 1 Yes 2 No
25. Was case referred to medical		26. Place of De	ath (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		eet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
			e, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
COL Cinneture and title of portifier		29c License number	29d Date signed (Month Day, Year)

Salisbury

State Registrar

31. Date filed (Month, Day,

NOMZA

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

USTINIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician/ ^M°Öct 12, 2011 7:45 AMM Ellen Turben Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany 717 Princeton Street Cumberland Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) WV Months Days Hours Aug 22 Director 214-36-0619 ′1939 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany Cumberland MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 717 Princeton Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 🗆 Yes 2 🗖 No Maryland 21215-0036 Specify Specify. white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Geraldine V. Wilt Lucian A. Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 717 Princeton Street Cumberland MD 21502 Charles Turben husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛚 Buriai 2 Cremation 3 Removal from State Sunset Memorial Park 10/17/20/11 Cumberland MD n 5 Other (Specify) Signature of neral Service L 22. Name an Scarpelli Fullieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Exter the disease, or con shock, or heart failure. List only lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Be Completed by Physician/Medical Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. the attending physician and thed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown Unknown this certificate has been signed by rail director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an performed 1 Yes 2 No 2 1 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 2 🗖 No ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title leted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Varner Forrest October 2011 /Medical Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner orchester Cambridge If Under 1 Year If Under 24 Hrs. meneral brchester 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min. 143-40-6094 Director 04/24 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f show Dorchester Wingate Maryland Funeral Director 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? Wingate Bishops Head Road U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Self Employed item 27 is marked other other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Dora Penna Forrest Varner ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 20 Sage Road, Toms River, NJ 08753 Susan M. Varner - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ocean County 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If iter any Injury or oth once. Pages 1 1 ☐ Boxial 2 ☐ Cremation 3 ☐ Removal from State 10-8-11 Donation Toms River, NJ 5 Other (Specify) Memorial Park 22. Name and Address of Facility ral Service Licensee Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 4cars abdominal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list and exerts) Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown is been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has I 2 2 No 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this
y filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Sheehan 5.0 october 4, 2011 H0068413 5 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennilar Funaivil Sheehan 503 H mair st. Cambridge MD 21613

Registrar

DHMH 17 Rev 1/2001

State

Varner,

32. Registrar's Signature

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Jenniler

OCT 06 2011

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Medical George Francis Vanagas Year 8:00 Ам October 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate House Linthicum Anne Arundel Funeral 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, 130-22-1211 Birthplace (State or Foreigr Country) Director Month Hours Min 1 XM 2 🗆 F 79 Nov. 3, 1931 New York 28a-f show should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State Director 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 15812 Presswick Lane 20716 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No 14. Race - American Indian þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. 3 Widowed 4 Divorced If Yes, Give Completed 1 Yes 2 No Specify: Year or Dates. UNK White 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) other traumatic event, the Printer Gov't Printing Office Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anthony Vanagas Violet McKensie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Jean Vanagas / Spouse 15812 Presswick Lane, Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Metro Crematory 10/8/2011 Baltimore, MD Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Physician/ Interval Between C9200 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 þ Hospital or Attending Physician: The law requires ath?

Completed To Be Certificate:

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Y
Part II. Other signi ficant conditions	1	Did tobacco use contribute to the cause of de
25. Was case referred to medical		Was an autopsy prior to completion of caperformed? Yes 22 No 1 Yes 2 No 24b. Were autopsy findings a prior to completion of caperformed? Yes 2 No 1 Yes 2 No 2 N
examiner?	Hospital: 26. Place of Death (Check only one))
27. Manner of Death Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 F 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28d. Descri	Residence 6 Other (Specify 05 (19)

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

vailable use of

Hos

6 Could not be

determined

a 0

strar's Signature

building, etc. (Specify)

28e. Place of Injury - At home, farm, street, factory, office

I Director: And in by the f

within 24 hours To the Funeral

filled in by

Medical

3 Suicide

29a. Certifier

(Check

only one) 29b. Signature and title of certiff

4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 34238 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0000 hrs Medical Examiner Trista Erin Whorton October 10, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington If Under 1 Year 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 24Hrs. **Funeral** Director Months Days Hours Country) Maryland 2XXF 216-13-3976 1 ☐ M 26 L1-02-1984 Usual Residence of Decedent 10c. City, Fown or Location 10d, Inside City Limits 1 Yes 2 No West Virginia Falling Waters be filed within 72 hours after death with the Maryland Berkelev Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 799 Nestle Quarry Road Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married 2XX No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2XX No specify: Specify: white <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene.

Tant: If item 27 is marked other than 'or other traumatic event, the Medical. 12 2 Accountant State Prison 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James Franklin Whorton æ Tracey Marie Bricker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey Marie Wrote 97 Jeanna Lane Falling Waters, West Virginia 25419 Mother Baltimore, N
permit. Pages I and 2
Department of Health
Important: If item 2
injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 crematory or other place) Removal from State 10-14-2011 Hagerstown to Maryland Cedar Lawn M.P. 5 Other Donation Fun S 22. Name and Address of Facility Williams ort, Maryland 21715 Osborne Funeral Home P.A. 425 S. Conococheaque St. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and **iModical** Death a Asphyxia due to Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Fuoral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED 23c. If yes, outcome of pregnancy IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Vear Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ę 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes No 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Subject hanged herself FOUND: Pending 1 Yes 2 ✔ No Oct 10, 2011 2138 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 201 East Sunset Ave, Williamsport, MD determined (Specify) carport Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number O.C.M.E. October 12, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OCME

State

Registrar

31. Date filed (Month,

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istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mildred WEINSTEIN Month 10:00 AM October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hebrew Home of Greater Washington Rockville 7. Age (In yrs. last birthday) 87 yrs. If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Months Hours Min. (Month, Day, New York 081-18-4946 Director Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pince. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 20879 7545 Cinnabar Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white If Yes, Give Year or Dates. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) 0 Harry Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20879 Susan Hankin, Daughter 7545 Cinnabar Terrace, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Israel Cemetery 10/12/11 Woodbridge, NJ 21. Signatur of Fuberal Service Lic nsee Torchinsky Hebrew Funeral Home Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial for use the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year been signed by the should be detached 1 ☐ Yes ≥ y 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed cate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? After this certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🛛 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: At earnpleted filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) minor Farle Do064871 10-11-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Fazli,

31. Date filed (Month, Day, Year) 0CT 12 2011

MD

6121

Registrar's Signature

Montrose

Rockville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death BARBARA WARD Month Physician/ October 8, 2011 7:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours **Director** 214-78-2310 1 □ M 2 🚟 53 Feb. 28, 1958 MD Usual Residence of Decedent show with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f MD Carroll Woodbine 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 1161 Breiten Court 21797 USA within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 A No Specify Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Special Educator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked o ೭ Richard Ward Julia Urbis traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) age 1 and 2 shant of Health a t: If item 27 is James Denzler/Husband 1161 Breiten Court, Woodbine, MD 21797 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State . Page 1 1 Burial 2 A Cremation 3 Removal from State 11, Oct. Department of Important: If any injury or Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 2011 21. Signatu of Funeral Service Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph. sici. n Liver disease or condition Cirrhosis Medical resulting in death) Due to (or as a consequence of) Examiner End-Stage Liver Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of Exami that the death certificate be executed Candida Peritonitis and that initiated events Due to (or as a consequence of) resulting in death) Last nding physician and use as the burial Physician/Medical P.O. Box 68760 E FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for Month Pregnant at time of death Day Year 1 ☐ Yes 2 년 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Septic Shock 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 🖾 No 1 X Yes 2 □ No To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 Yes 욘 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🛚 Natural injury 5 Pending after death. Accident filled in by the Investigation 6 Could not be М Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral D

Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State

31. Date filed (A

NUO

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

WRIGHT

D56108

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

Oct. 8, 2011

Physician/ Medical **Examiner Funeral** Director 28a-f show be notified at Director ò ms 23a Funeral er than "natural", or iter the Medical Examiner ģ Baltimore, Maryland 21215-0036 Completed permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Be မ Physician/ Medical Examiner Examin burial-transi and attending physician Physician/Medical requires that the death certificate be Box 68760 the as use ρ the P.O. signed by \$ Records, peen has

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pendleton L. Woodson 0936 October 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memoria 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days Hours 577-26-6271 92 5-(Month, Day, Year) Washington D.C. Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Talbot 1 Tes 2 X No Cordova 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12680 Peach Lane 21625 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bace - American Indian. Black, White, etc. 1 Never Married 2 X Married 1 ▼ Yes 2 □ No If Yes, Give 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Atomic 4 Illustrator Energy Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pendleton Nelson Woodson Lisler Geraldine Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Ewing Daffin Executor 12680 Peach Lane Cordova, MD 21625 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rock Creek Cemetery 10-14-2011 Washington 21. Signature of Funeral Service Licensee Name and Address of Facility Llows, Helfenbein & Newnam Funeral Home P.A. O S. Harrison St Easton MD 21601 MER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Bowel disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 2 🗌 No 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform this certificate 1 Yes 2 No Yes 24 hours after ueau... **e Funeral Director**: After this certifica Nated filled in by the funeral director, Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check the the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within To the 29b. Signature an 29d. Date signed (Month, Day, Year) DU053815 g person who completed cause of death (Item 23a) (Type, Print)

ULIMOUD 9120 Market St Deuton Mo ame and address Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		,	For State Registrar	State	of Maryland	_	artment of F		-	giene Reg. No.	201	1 21.21.
В	Physicia	an/	1. Decedent's Name (Fir.		¥07 - 4. 4				2. Date of De	ath	Year	3. Time of Death
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	Examir	ner	PENINSULA	Regional Ale	,	Pater	4b. City, Iown, oi	r Location of Death		4c. Cou	Inty of Death	
	Funeral	Г	5. Social Security Number 214-34-7738	er 6. Sex_	7. Age (In yrs. Ia.	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birth	nplace (State or Foreign
1	Director	ļ	Usual Residence of De	I LI M Z LI F	' '	Yrs.			9-6-1			/ld.
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	vith the M 23a or 24 st be not	eral Dir	10e. Street and Number 306 E. Ch	ew Ave.			10f. Zîp Code 21663	3		10g. Citizen	of What Cou	intry?
	r death v r items iner mu	y Funeral	11. Marital Status 1 ☐ Never Married		edent Ever in U.S. orces? 2 No	13. \	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. F	Race - Ameri	etc.
900	rurs after tural", o al Exam	ted by	3 Widowed 4 🗆	Divorced If Yes, Giver Year or D	e No-		☐ Yes 2 No			Spec	_{cify:} Whit	te
1215-	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed		Decedent's Education only highest grade completed y (0-12) College (1		101	ent's Usual Occup ind of work done of NOT use retired) S ter Bar	decidence and all all colors	king		f Business/Ir $Styl\epsilon$	
and 2	oe filed wi ental Hygie ced other cevent, ti	To Be (17. Father's Name <i>(First,</i> Mari	Middle, Last)				18. Mother's Nar	ne (First, Middle, L. Geor	Maiden Surna		
Mary	ge 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mental Hygiene. If if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/F Gloria J.	Relationship (Type, Print) Watts/Wife		19b Mailir 306	g Address (Street & E. Chew A				n, State, Zip 2 166 3	Code)
Baltimore, Maryland 21215-0036	permit, Page 1 and Department of Heal Important: If Item 3 any injury or other once.		20a. Method of Disposition 1 A Burial 2 Cr 4 Donation 5	emation 3 - Removal from	State 20b. Pla	ace of Dispo metery, crem Vet C	sition (Name of latory or other place emetery	10-3	Date -2011	20c. Location	on - City or T	
Balt	permit. Departr Importa any inju		21. Signature of Funeral		C.F.S.P.	PA P	n'integrated Again€ O. Box 5	strowski 18 St. M	Funera lichaels	1 Home	P.A. 21663	
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	ite be executed hysician and the burial-transit	al Exar	Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a conseque	ence of):						
260	cate be physic s the b	edica		d								
Box 68760	ionre hospital or Attending Priysician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Physician/Medical	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	nant at time of de	death 3 🗌	Ectopic pregnanc Other (specify)	у			Date of deliv	very Day Year
Division of Vital Records, P.O.	es that the igned by be detac	by		conditions contributing to d	eath but not resul	ting in the u	nderlying cause giv	ren in Part I.				he cause of death?
ords	w requires s been s 2 should	Completed							24a. Was a	an 24	b. Were auto	psy findings available
- Rec	Physician: The law this certificate has ral director, page 2		25. Was case referred to	modical					1 Tes	rmed2	death?	ompletion of cause of
Vita	ysiciai is certi directo	To Be	examiner?	Hospital:	Inpatient 2 🗆 E	R/Outpatien	Otho	er:	<i>k only one)</i> ome 5 □ Resid	Jence 6 \square C	Other (Specifi	v)
on of	naing Ph ath. :: After th e funeral	icate:	27. Manner of Death 1 Natural 5 2 Accident	28a. Date		8b. Time of injury	28c. Injury work	at	28d. Describe h			//
Jivisio	al or Attend s after death I Director: A d in by the f	Certificate:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be 28e. Place	of Injury - At homing, etc. (Specify)	ie, farm, stre	et, factory, office		28f. Location (S City or Tow		nber or Rura	l Route Number,
_	n 24 hours n 24 hours ne Funera	Medical	(Check 2 L M	ertifying Physician: To the be edical Examiner: On the base ertifying Nurse Practitioner	is of examination a	and/or investi	gation, in my opinio	n, death occurred a	it the time, date a	nd place, and	due to the ca	use(s) and manner stated.
	vithi To t		29b. Signature and title of		2-		29c. License			29d. Date sig	ned (Month,	
10	+VA		30. Name and address of	person who completed cause	e of death (Item 2	(3a) (Type, Pr	int)	<i>St.</i>	5/11/5/4/			
ĺ	Stat Registra	e	31. Date filed (Month, Day	P 3 0 2011 32.R	gistrar's Signatu	B. A	Alloll		/			

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		For State Registrar	State of Ma	•	ertificate of			eg. No. 2 N	11 31,21,
		Registrar Decedent's Name (First, Middle, L	_ast)				2. Date of Deatl	h	3. Time of Death
Physicia		Catherine M. Wei	r				Month October		8:05 P. M
/Medic		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death		4c. County of I	Death
,		Somerford House			Frederi			Freder	
Funeral			Sex 7. Age	(In yrs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
Director		022-20-8359 Usual Residence of Decedent		84 Yrs.			09/22/1	927	MA
fand ow It		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Mary I-f sh fied a	ţċ	MD Freder	ick	Frederic	k				1 X Yes 2□No
th the	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of Wha	t Country?
23a c	교	2100B Whittier D	r.,#309		21702			USA	
er dea tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N	Ever in U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		American Indian, Vhite, <i>e</i> tc.
s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	1 □Yes 2 No	Specify:		Specify:	IJb 1+0
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and 2 should be filed within 72 hours after death with the Maryland astill hand Mental Hygiene. In 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	(Type. Print)		ling Address (Street				
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			ematory or other pia Cremator	i	1/2011	Frederick	· MD
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Physical direction	2	1 ☐ Yes 2 K No 27. Manner of Death	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpati	ent 3 DOA			ence 6 Other ow injury occurred	(Specify)
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Atten r deal ector	ifica	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inju	ury - At home, farm, s	street, factory, office		28f. Location (Si	treet and Number	or Rural Route Number,
talor s afte at Dire	Certification: To	4 nomicide	building, etc	c. (Specify)			City or Town	r, State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal	(Check only 2 Medicel Ex	Physician: To the best aminer: On the basis o	f examination and/or					
thin 2 the 1 the 1	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.	29c. Licen	se number	2	29d. Date signed (i	Month, Day, Year)
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5		30. Name and address of person wh	no completed cause of d	eath (Item 23a) (Type					
)				EDEWICK	mg &	21702			
Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	barker		,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Nettie E. Watkins October 2:30p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Shady Grove Hospital Rockville Montgomery Social Security Number 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Hours Min March 12, Maryland Director 100 Yrs 217-76-7343 Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Montgomery Mt. Airy 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 9271 Brown Church Road 21771 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ō Completed by 1 Never Married 2 Married hours after 2 X No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ be George Burdette Elizabeth Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is R. Elaine Cordell / Daughter 9270 Brown Church Road, Mt. Airy, Maryland 21771 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Methodist Damascus, Maryland. Cemetery 21. Signature of uneral Service Lice Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between cardiac Immediate Cause (Final Onset and Death arrest Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner respirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine maggive stroke Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 : autopsy performe death? Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours atter ueau... he Funeral Director. After th 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of_certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/8/11 71323 Rubull 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Mary land 20850 Ushakiran Yenigalla Year) 31. Date filed (Month 32 Registrar's Signatu Day, State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 201 T 6:37 P Paul Willoughby Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 10094 Quail Knob Lane Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 220-94-9479 1 🕅 M 2 🗆 F 49 Aug. 14, 1962 Maryland Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 🗆 Yes 2 🔀 No Maryland| Frederick Frederick ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 10094 Quail Knob Lane 21702 United States 12. Was Decedent Ever in U.S. Armed Forces?
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(Give kind of work done during most of working life. DO NOT use retired)
N/A 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Willoughby Aice Thompson Alice Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Department of Health ar Important: If item 27 is any injury or other trau once. 10094 Quail Knob Lane, Frederick, MD 21702 Diane Willoughby / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 D Burial 2 X Cremation 3 D Removal from State 10/8/2011 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or shock, or neart failure List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death only one cause on each line Immediate Cause (Final Physician/ PSIS disease or condition resulting in death) 1.262. Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year signed by the at d be detached for Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has k performed 1 Yes 2 No Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson On Svile E Fredorick, MO

State Registrar Gerard

DelGri

Thomas

egistrar's Signature

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

elen Watkins		State of Marylaı I-For State Registrar	nd / Department <i>Certificate</i>		nd Mental Hy		201	1 3424
Physicia edical Exami	ın/	1. Decedent's Name (First, Middle,Last) HELEN M. WATKINS			_	2. Date of Death Month October 16	Day Year	3. Time of Death 1745 hrs
7		4a. Facility Name (if not institution, give street and num	ber)		or Location of Death		4c. County of Death	1
Funeral	4	1530 Kerr Road 5. Social Security Number 6. Sex	. Age (In yrs. last birthday)	Whiteford	ear If Under 24Hrs	. 8. Date of Birth	Harford (MM/DD/YYYY) 9. Bir	thplace (State or
Funeral Director		178-22-9465 1 M X F	0.0		ays Hours Min.	-	Foreig	untry) PA
any	F	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	5	MD Harford	Whi	teford				1 Yes 🏋 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 1530 Kerr Road		10f. Zip Code 21	160	10	g. Citizen of What Cou USA	ntry?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she at Examiner must be notified at once	uneral	11. Marital Status 1 Never Married 2 Married Armed For			Hispanic Origin? (Sp an, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
after dea al", or in ner mus	by Fu	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	2 X	Yes 2 X	No specify:		SpecWhite	e
hours a	ted b	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-	l or 5+) during	g most of working li	oation (Give kind of vife. DO NOT use reti		16b. Kind of Business/	
vithin 72 ene. er than	Completed	12	Se	cretary			Civil Se	ervice
MD 21215-0036 At 2 should be filed within 72 hours after the and Mental Hygene. a 27 is marked other than "natural", umatic event, the Medical Examiner.	Be Co	17. Father's Name (First, Middle, Last) Unknown			18.Mother's Name		aiden Surname) ecca Kilgo	ore
hound hour is in strict	2	19a. Informant's Name/Relationship (Type, Print)					ber, City or Town, State	
Tore, MD 2 ages I and 2 shount of Health and Nt: If item 27 is not then traumatic	ŀ	James E. Haupt, III/ 20a. Method of Disposition	20b. Place of Dis	position (Name of	cemetery.	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Her Important: If ite		1 X Burial 2 Cremation 3 Removal fro 4 Donation 5 Other Specify:	Dallast			/20/201	1 Dallast	town, PA
Baltimore, MC permit. Pages I and 2 s Department of Health as Important: If item 27		21. Signature of the uneral Mervice Incomes		2. Name and Addre [arkins	ess of Facility F.H. Inc	c., Del	ta, PA	17314
Physician		23a. Part I. Enter the disease, or complications that ca failure. List only one cause on each line.	used the death. Do not ente	er the mode of dyin	ig, such as cardiac c	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner			tic Cardiovascular E	Disease				Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	consequence of):					<u> </u>
ecuted and transit		events resulting in death) Last Due to (or as a d.						
60, nte be exe hysician e burial -	ledic	UNPENDED AMENDED IF FEMALE: 23c. If yes. o	strome of pregnancy				23d. Date of deliver	<u></u>
30x 6876 leath certificate e attending phy for use as the l	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	at at time of		3 Ectopic pregna	ancy		Day Year
Box te death of the atter	hysic	1 Yes 2 V No 9 Unknown g death Unknown	vn	Other (Specify)				
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Foureral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - trans	þ	Part II. Other significant conditions contributing to	death but not resulting in th	he underlying caus	e given in Part I.	23e. Did to	bacco use contribute to	the cause of death? bably 4 Unknown
ords, w require s been si	Completed					24a. Was a	sy prior to	utopsy findings available completion of cause of
of Vital Records, ig Physician: The law requirenthis certificate has been surer this certificate has been sureral director, page 2 should	Comp							es 2 No
Vital ysician: his certif	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Ir	patient 2 ER/Outpati		Other Nursi		Residence 6 🗸 Othe	er: Scene
n of ling Phy After the	on: T	27. Manner of Death 28a. Date of (Month,	f Injury Day, Year) 28b. Time		njury at Work?	28d. Describe h	now injury occurred	_
Division al or Attendi rs after death. al Director: #	fication	2 Accident Investigation 28e. Place	of Injury - At home, farm, s					ural Route Number, City
Divi	Certification: To	4 Homicide determined (Specify)				or Town, S		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 Certifying Physician: To the best one) 2 ✓ Medical Examiner: On the basis of	examination and/or invest	ccurred at the time, tigation, in my opini	, date and place, and ion, death occurred	d due to the caus at the time, date	e(s) and manner as sta and place, and due to t	ited. he cause(s)
To To So I	Me	29b. Signature and title of certifier	A-/		ense number		29d. Date signed (Mi	
Jan		30. Name and address of person who completed caus	of death (Item 23a)	0.0	C.M.E. 		October 17, 201	
Ign		Jack Titus MD. Deputy Chief Medic	al Examiner 900 V	V. Baltimore S	treet, Baltimore	, MD 21223		
St Regis	ate trar	31. Date filed (Month Day (day) 32. Re	gistrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per inf 921 11-1-11 wt state of Maryland / Department of Health and Mental Hygiene AMEND ITEM#20b, perFH C921 19/2011, WS 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 2011 anton /Medical Xtober 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bon 1405/61ta Sec Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Kimore OUYS (Total If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 🍑 Days 216-34-9644 Months Director 3 1940 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations to a rediffical. Director MD 14∐Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1656 Bruce St. 21217 USA filed within 72 hours after death v Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian,
Black, White, etc.
Black
Specify: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 🕅 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 🖾 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Plummer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie MacNell Payton Anderson, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andre A. Anderson-Grandson 1656 Bruce Ct. Baltimore, MD 21217 20b. Place of Disposition (Name of cemetary, crematory or other place)
Wood Lawn Cemeter
Mt. Carmel Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD nel Cemetery 11/8/2011 Ballingle,
22. Name and Address of Facility March F/H 1101 E. 4 □ Donation 5 □ Other (Specify) Carmel Cemetery 21 Signature of Funeral Service Licenses Ave. Baltimore, MD 21202 23a. P. rt.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Im nediate Cause (Final disease or condition resulting in death) **Physician** 4000000 montes /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any leading to improve a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No certificate has page 2 s 24a. Was an autopsy performed Division of Vital 2 1No 1 □ Yes Hospital or Attending Physician; filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1☐ Yes 2☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No hin 24 hours after death the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely (Check only one) o the Howithin 2/ 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Balknorp 2000 05 31. Date filed (Month, Day, Year) 32. Registrar's S State 7 2011 OCT 2 Registrar

To Be Completed by Funeral Director

Please	Type or Prin				-	_	le.
For State Registrar	State of Mar		artment of t rtificate of t		, ,	ene g. No. 20	11 34248
1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Ye	3. Time of Death
Clyde George Arc 4a. Facility Name (if not institution, give	cher-Burton		4b City Tayon	v I continue of Dooth	October	25 20 4c. County of D	
Stella Maris Hos			Timo	or Location of Death P nium	1	ore	
	Sex 7. Age (I	n yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye) 04/13/19		Birthplace (State or Foreign Country) MD
Usual Residence of Decedent 0a. State 10b. County MD n ₁		0c. City, Town or Lo	ocation Ltimore				10d. Inside City Limits 1 🙀 Yes 2 □ No
0e. Street and Number 3838 Roland Aver	nue Apartmer	nt 501	10f. Zip Code 212	11		g. Citizen of Wha	t Country?
1. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of F If Yes, specify Cuba 1 ☐ Yes 2 ☐ XNo	an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	Black, V	American Indian, Vhite, etc. White
15. Decedent's E (Specify only highest gi	Education ade co <i>mpleted)</i> College (1-4 or 5+)	(Give life. D	dent's Usual Occup kind of work done IO NOT use retired) Yer Spinn	during most of wor	king	Sb. Kind of Busin	
7. Father's Name (First, Middle, Last) Allister Archer-	-Burton				ne (First, Middle, Mai Crawford	iden Surname)	
19a. Informant's Name/Relationship (1 Dana Johnston- I	**				ral Route Number, Ci ninster, M		; Zip Code)
0a. Method of Disposition 1 ☐ Burial 2 【文Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		20b. Place of Dispo cemetery, crer Ardent Ci	matory or other plac	^{ce)} 10.	I	C. Location - City Hanover,	
21. Unat ri of Funeral Sirv	TO S	JG 45	Name and Addre Chn L. Wi 517 Park	illiams F Heights	uneral Di: Ave Baltin	rectors, more, MD	P.A. 21215
23a. Palt 7. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.	e death. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
resulting in death)	a. SEPSIS Due to (or as a co	onsequence of):					
Sequentially list conditions, fany, beging to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to or as a co	oneschettes of)					
that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):					
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of particles of Live Birth 2 4 Pregnant at tir		☐ Ectopic pregnand	ру		23d. Date of Month	f delivery Day Year
Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	inderlying cause gi	ven in Part I.	23e. Did tobad	1	e to the cause of death? Probably 4 □ Unknown
			1		24a. Was an autopsy performe 1 \(\subsection Yes \) 2	prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
5. Was case referred to medical examiner? 1 ☐ Yes 2 👿 No	Hospital:		Oth	ace of Death (Chec			
7. Manner of Death 1 X Natural 5 Pending	28a. Date of injury (Month, Day, Ye	2 ER/Outpatier 28b. Time of injury	nt 3 L DOA 28c, Injur work	4 ∐ Nursing H y at	ome 5 Residence 28d. Describe how		pecify) HOSPICE
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, streepecify)		TES Z LI NO	28f. Location (Stree City or Town, S		Rural Route Number,
(Check 2 Medical Exam	sician: To the best of my iner: On the basis of exam se Practitioner: To the be	ination and/or invest	tigation, in my opinio	on, death occurred a	at the time, date and p	place, and due to t	the cause(s) and manner stated.
9b. Signature and title of pertifie		2	29c. License	e number	29d	I. Date signed (M	onth, Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

> State Registrar

JACKIÉ

JONES,

31. Date filed (Month, Day, Year)

OCT 2 7 2011

CRNP

Medical Certificate: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY RD.

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

201

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 3 4 2 4 9

Keifon Eric Butl	er, J	r. Si	ate of Marylar	•	tment of H ficate of D		d Mental		eg. No.	11 3464	
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Keifon Eric Butler, Jr.						2, Date of Deal Month October 2	h Day Year 2, 2011	3. Time of Death 2324 hrs	
		4a. Facility Name (if not institution, give street and number) University Hospital					Location of De			/A	
Funeral Director		5. Social Security Number 169-79-3070	6. Sex 7 1 X M 2 F	, Age (In yrs. last		f Under 1 Yea Months Day:		Ars. 8. Date of Bir 9/21/		9. Birthplace (State or Foreign Country) MD	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show any ctraumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State				Of, Zip Code 10g. Citizen of What U.S.					
		11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:			If Yes,	as Decedent of Hispanic Origin? (Specify Yes or Noves, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No specify:			White, etc. Specify: Black		
		Elementary/Secondary (0-12) N / A College (1-4 or 5+) N / A N / A				Usual Occupation (Give kind of work done it of working life. DO NOT use retired)			16b. Kind of Business/Industry N/A		
		17. Father's Name (First, Middle, Last) Keifon E. Butler, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add					18.Mother's Name (First, Middle, Maiden Surname) Erika Brown (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
		Erika Brown -Mother 5327 Patrick Henry Dr. Baltimore, MD 21225 20a Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State									
Baltimore permit. Pages 1:8 Department of H. Important: If it		1 🕅 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 1. Si nature of Funeral Service Licensee / 1. Si natur									
Physician	8 9	North Ave. Baltimore, MD 21202 26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and									
xaminer	or condition resulting in death) Due to (or as a consequence of):								Death		
	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
760, cate be executed physician and the burial - transit		events resulting in death) Last Due to (or as a consequence of): d.									
	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of					
Box 68760 e death certificate b the attending physi	Physician/Me	past 12 months?				eath 3 (Specify)	Ectopic pre	gnancy	Month	Day Year	
P.O. se that the gned by he detach									ute to the cause of death? Probably 4 Unknown		
1 of Vital Recelling Physician: The late After this certificate harmoneral director, page 2	Completed by	24a. Was an autopsy findings availa autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No								or to completion of cause of ath?	
	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA No No 1 Other Nursing Home 5 Residence 6 Other:									
		. 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Injury at Work? 28b. I						28d. Describe h			
Divis spital or A tours after of	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fa (Specify) rowhouse				or Town, Stat			tate) 5327 Pa	eet and Number or Rural Route Number, City te) 5327 Patrick Henry Dr Park, MD.	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
0	Σ	29b. Signature and title of certifie						29d. Date signed (Month, Day, Year) October 23, 2011			
of perd		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									
	tate	31. Date filed (Month, Day, Year)	32 Regi	strar's Signature							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 34250 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Virginia G. Barnes 7:300 M nct 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) Examiner Riverview Nursing Center Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours March 3, 1916 MD **Director** 218-32-3495 1 🗆 M 2 🖫 F 95 Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10a. State 10c. City, Town or Location the Maryland Director Middle River notified Baltimore MD 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ms 23a or must be r Funeral 21220 2111 Firethorn Road USA items регтіт. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Ith and Mental Hygiene.
27 is marked other than "natural", or iter traumatic event, the Medical Examiner Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 ₩Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) John Hopkins Mail Clerk 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gertrude Winter Vernon Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111 Firethorn Road Baltimore MD 21220 Health tem 27 Beverly Barnes /daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of P Important: If ite any injury or ot once, Burial 2 Cremation 3 Removal from State Gardens of Faith 10/28/11 Rossville MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility 300 Connelly Funeral MAce Home Ave. Balto, MD of Essex 21221 en 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on ions that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final dia C Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner mons Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examil and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician ar as the burial-t Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 attending IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day 1 ☐ Yes 2 № 9 ☐ Unknown the Unknown this certificate has been signed by it all director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 24 hours after death.

Funeral Director: After this certific stely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ė Hospita 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Determiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M-D 10-25-2011

State Registrar 709. BASTERN

MD-21221

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NASREM

32. Registrar's Si

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1<u>8</u> October Graham Babylon 2011 10:07A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Carroll Westminster . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign Funeral Days 1 **№** M 2 □ F Months oct. 13, 1918 Maryland Director 93 126-22-7480 Usual Residence of Decedent or 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 925 Wakefield Valley Rd. U.S.A. 21776 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married X Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates.1936-39 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 owner/operator burial vault mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Guy W. Babylon Sarah Louise Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Mary K. Babylon/wife 925 Wakefield Valley Rd. New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 10/21/2011 nr. Linwood, MD at e of Foneral Service Lio 22. Name and Address of Facility Hartzler Funeral Home attarine New Windsor, MD 21776 310 Church St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner CEURA Sequentially list conditions. ner ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed tranand that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician a should be detached for use as the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 s autopsy performed? Yes 2 No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗆 Yes Other: <u>|</u>2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death s after death. 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature an 29d. Date signed (Month, Day, Year) DO05-95-52 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*

DHMH 17 Rev 7/2009

State Registrar GOURISHANKAR

31. Date filed (Month, Day, Year) ----

C

NACRNNA

Registrar's Signature

TWA POOLE RD WESTMINSTER MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34252 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 24, 2011 2:41 P M LeRoy Ellis Bowen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 6. Sex 5. Social Security Number Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Year) 916 1 □ M 2 🕅 F Davs October I, Hours Min. Ok Lahoma Director 456-12-6323 95 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 28a-f 1 🗌 Yes 2 🔀 No Chevy Chase Maryland Montgomery 23a c 5 10f. Zip Code 10g. Citizen of What Country? Funeral must 4903 De Russey Parkway 20815 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, 0 Completed by Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ian "natural", Medical Exar If Yes, Give Specify: 3 X Widowed 4 Divorced Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve ပ LeRoy Ellis Hortense Lindsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 6117 Elaine Drive, Jefferson, Maryland 21755 Kathleen Bowen Noer/Daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Department of P Important: If ite any injury or ot 20c. Location - City or Town, State November 1 cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Richlawn Cemetery 2011 Waverly, Tennessee 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ Hydropneumothorax Pneumonia resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Examiner Due to (or as a consequence of) burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 1 ☐ Yes 2 XNo Month the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Dementia, Atrial Fibrillation, Congestive Heart 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Failure, Hypertension Hospital or Attending Physician: The law has autopsy perform Yes 2X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After XNatural 5 Pending work?
1 \(\sum \) Yes 2 \(\sum \) No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu after death. Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 26 201

Florin Rusu, M.D. 400 West 7th Street, Frederick, Maryland 21701

058808

29d. Date signed (Month. Day, Year)

25120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ OCTOBER 22 2011 BROWN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN 9. Birthplace (State or Foreign 6, Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Social Security Number **Funeral** (Month. Dav. Year) 1 🖁 M 2 🗆 F 022-18-0434 Director 08/07/1922 89 Usual Residence of Deceden 28a-f show 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director PIKESVILLE MD BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21208 1500 BEDFORD AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: Completed 3 X Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ENTERTAINMENT 12 PROMOTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNKNOWN Department of Health and Ment Important: If item 27 is marke any injury or other traumatic UNKNOWN JOHN PIMENTAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6906 YATARUBA DRIVE, BALTIMORE, MD 21207 LEONARD ESTIS / COUSIN 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 10-26-11 MARYLAND VETERANS e of Funeral Service vice SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 212-8 23a. Part 1. Enter the disease, or compli ations that caused the shock, or heart failure. List only one tause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a ponsequence of: if any, leading to in made cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 2 No 9 Unknown P.O. Papath Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed? Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 2 17 10 Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28h Time of 1 Anatural 5 Pending n 24 hours after death.

e Funeral Director: Aft
bletely filled in by the fur 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/22 2011

3. Time of Death

MA

01:35A M

1 Yes 2 No

USA

Approximate Interval Between See and Post

Day

Year

State Registrar

31. Date filed (Month, Day, Year)

KAMEN W.

Sut 203 Balfinine, WD 21209 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

11-07988 Edward Bardney Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011	3425
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	,	1-For State amend #20a-c Per File Ame Ste Registrar	1 <i>0f/03at</i> 12011 JH	Reg. No.	
Physici		Decedent's Name (First, Middle,Last)		Date of Death Month Day Ye	3. Time of Death 0135 hrs
edical Exam	iner	Edward Roosevelt Bardney, Jr. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of I	October 24, 2011 Death 4c. County	
		University Hospital	Baltimore City		n/a
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			Y) 9. Birthplace (State or Foreign
Director		213-92-9275 1 M 2 F 38	Yrs. Months Days Hours	Min. 07/11/1973	Country) MD
x	1	Usual Residence of Decedent	tion		10d. Inside City Limits
W 4		10a. State 10b. County 10c. City, Town or L. MD 10c. City, Town or L.	Baltimore		1 X Yes 2 No
daryland 28a-f show any 1 at once,	tor	10e. Street and Number	10f. Zip Code	10g. Citizen of W	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Mait. If item 27 in marked other than "natural", or items 23a or 28a-f sho nor other traumatic event, the Medical Examiner must be notified at once.	Director	2907 White Avenue	21214	USA	
eath with items 2.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		ce - American Indian, Black, ite, etc.
ifter d II", or	by Fu	3 Widowed 4 Divorced If Yes, Glva Year or Dates:	Yes 2 No specify:	Specify:	Black
nours a	9 p	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	dent's Usual Occupation (Give kir g most of working life. DO NOT us		Business/Industry
11215-0036 In the filed within 72 hours after dealed Hygiene. antked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	laborer		Sons Moving Co
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	5 	17. Father's Name (First, Middle, Last)		Name (First, Middle, Maiden Surnam	e)
be file	8	Edward Roosevelt Bardney, Sr.		e Washington	
D 21 should I and Mer	₽	n l		er or Rural Route Number, City or To Baltimore, MD 212	
and 2 sho ealth and tem 27 is traumati			sposition (Name of cemetery,		ı - City or Town, State
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 77 Department of Health and Mental Hygiers. Important: If tiem 27 is marked other than injury or other traumatic event, the <u>Medical</u>			r other place) Cemetery	10.29.2011 Balt:	imore,MD
Balti permit. Departm Importi		2 Signiture of Funda Struce Deserted	2 Name and Address of Facility John L. Williams 4517 Park Hots	s Funeral Directo Ave Baltimore, MD	ors, P.A.
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	er the mode of dying, such as care	diac or respiratory arrest, shock, or he	eart Approximate Interval Between Onset and
- Medical ≟xaminer	a d	Immediate Cause (Final disease a. Multiple Gunshot Wounds			Death
		or condition resulting in death) Due to (or as a consequence of): b.			
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
d sit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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760, cate be physici	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of	•
Box 687 e death certific the attending	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 1 4 Pregnant at time of death	Fetal death 3 Ectopic p Other (Specify)	oregnancy Month	Day Year
Box death	nysi	1 Yes 2 No 9 Unknown 9 Unknown	Other (eposity)		
P.O.		Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part		tribute to the cause of death? 3 Probably 4 Unknown
Records, The law require ficate has been si, page 2 should b	Completed			24a. Was an 24b.	. Were autopsy findings available prior to completion of cause of
tal Recolemn: The law certificate has ector, page 2 sl	dwo			performed?	death? 1 ✓ Yes 2 No
Vital Reconsider: The land in sertificate had director, page 2	BeC	25. Was case referred to medical	26.Place of Death (C	heck only one)	
Vit hysici	T E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpa		Nursing Home 5 Residence 6	
Division of Vital all or Attending Physician: rs after death all Director: After this certi- led in by the funeral director		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Oct 24, 2011 28b. Time 0057 hrs		28d. Describe how injury occu Subject shot	rred
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc.	or Town, State)	ber or Rural Route Number, City
Dispital hours and filled	Ce	4 Memicide determined (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge death of		2200 Linden Avenue, Baltir	
the Ho bin 24 the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest			
To with	Mec	29b. Signature and title of certifier	29c. License number	29d. Date sig	ned (Month, Day, Year)
		6 heert 7	O.C.M.E.	October 2	24, 2011
7		30. Name and address of person who completed cause of death (Item 23a)	/ Raltimore Street Balling	nore MD 21223	
		Zabiullah Ali, M.D. Assistant Medical Examiner 900 V 31. Date filed (Month, Day, Year) 32. Registrar's Signature	· · · · · · · · · · · · · · · · · · ·	IOIE, IVID 2 1223	
S Regis	tate	31. Date floor 2 6 2011 Survey 32. Registrar's Signature	and a		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Las Date of Death 3. Time of Death **Physician** /Medical 4b. City, Town, or Location of Death acility Name (If not institution, give street and numbe 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 9/12/2011 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 F MD **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a State 10b Counts 10c. City, Town or Location show or 28a-f shov notified at MD N/A Baltimore 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō death with 21224 ral", or items 23a o Examiner must be 6216 Carbore Way USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) NZ A (1-4 or 5+) Elementary/Secondary (0-12) N/A N/A traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Malcolm P. Cummings II Hevanle Bailey ည 19a. Informant's Name/Relationship (Type. Print)
Hevanle Bailey-Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6216 Carbore Way Baltimore, MD 21224 Department of Health a Important: If item 27 is any injury or other trainonce. 20b. Place of Disposition (Name of Cemetery Grematory Cother place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🖺 Burial 2 🗌 Cremation 3 🗌 Removal from State 10/20/2011 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signatu e of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. Ave. Baltimore, MD 21202 23a. Pan I. Enter the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one each line. Approximate Interval Between Onset and Death Imm piare Cause (Final **Physician** Nou dise se or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran attending physician Box 68760, Physician/Medical use as IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy ρ in the past 12 months? Month Day Yea Pregnant at time of death 5 Other (specify) 2 No be detached P.O. Unknown the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2₩ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 2 🗌 No Yes 2 | No 1 Tyes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 🗌 Yes No 2 ER/Outpatient 3 DOA Inpatient 5 Residence 6 Other (Specify) To the Hospital or Attending Physiswithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. ၉ 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred Medical Certification: Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only one) 29b. Signature 29d. Date signed (Month, Day, Year, 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 11595

State of Maryland / Department of Health and Mental Hygiene 34256 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ 6:19рм oct.23 *J*o seph Cascio Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** . County of Death Baltimore Middle River 3213 Foxglove Lane Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Jan. 18, 1936 Days Hours 216-34-3047 75 MD Director 1 🔀 M 2 🗆 F 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director Middle River notified MD Baltimore 28a-f 1 Yes 2 X No 10e. Street and Number r items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21220 3213 Foxglove Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural" White Completed 3 Widowed 4 Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Custodian 3rd Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ Catherine Imbragulio Arsrio Cascio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1649 Millersville Road Millorsville 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau once. Stewart Sullivan / nephew Millersville MD 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Most Holy Redemeer 10/27/1 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final len Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò HEART ONGESTIVE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed DEFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death Funeral Director; After this certificate has performed Yes 2 2 🗌 No 1 Yes Hospital or Attending Physician: completely filled in by the funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier no) 016728 10-24-2011 Leath (Item 23a) (Type, Print)
6830 11051, TML Dr 104 BALT MD 21237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IMO 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ KATHLEEN MARIE CAVEY OCTOBER 25 2011 8:40p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7903 ROSELAND AVENUE ROSEDALE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 🗆 M 2 🔀 F 0597777 1965 217 96 8474 46 MARYLAND **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director MD BALTIMORE ROSEDALE 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7903 ROSELAND AVE 21237 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: WHITE Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) HOMEMAKER HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GILBERT F. PHELPS MARGARET M. WINTERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRIAN R. CAVEY/HUSBAND 7903 ROSELAND AVE BALTIMORE, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State CEDAR HILL 10/28/11 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) year Medical Due to (or as a consequence of): Examiner Seque tially list conditions if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): ending physician and use as the burial-transit The law equires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 XResidence 6 \square Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 urtl 201

HMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34258 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1224 M Robert Delain Campbell 10 Medical 4a. Facility Name (if not institution, give street and nur **Examiner** 4b. City. Town, or Location of Death 4c. County of Death SALISBUI HICOMICO KOGIONAL 9. Birthplace (State or Foreign Age (In yrs. last birthday, Date of Birth **Funeral** Months **Director** 1 🗶 M 2 🗆 F 31, 1938 Pennsylvania 72 Usual Residence of Decedent show 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified a 1 X Yes 2 No Virginia Accomack Horntown ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral U.S.A. 6117 Bluebill Drive 23395 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 X Married XYes 2 No within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 3 Wildowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) painter/ home improvement/ Elementary/Secondary (0-12) College (1-4 or 5+) crane operator 10 salvage co. Be 17. Father's Name (First, Middle, Last) rage 1 and 2 should be file
Department of Health and Mental H
Important: If item 27 is marked oth
any injury or other tree 18. Mother's Name (First, Middle, Maiden Surname) မ Elmer Stiles Campbell Mary Calhoun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Horntown, VA 23395 Doris B. Campbell/wife P.O. Box 396 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosedale Cemetery 10/25/2011 | Martinsburg, WV Signature of Funderal Service Licenses 22. Name and Address of Facility Hartzler Funeral Home Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COMONANY disease or condition Medical resulting in death) to (or as a consequence of **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-trar resulting in death) Last Due to (or as a consequence of): attending physician for use as the buris Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Year Pregnant at time of death the g 🗌 Unknown g Unknown þ Part II**. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24b 24a. Was an Jas performed? Yes 2 certificate | 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No ၉ 1 Inpatient 2 DER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 Pending 124 hours after death, e Funeral Director: At eletely filled in by the fu M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

MD, 100 E CARROLL STREET, SALISBURY, MD 21801

me and address of person who completed cause of death (Item 23a) (Type, Print)

DESMARIS

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	1	For State	se Type or Pr i State of M		d / Depa	idelible Inlartment of F artment of E tificate of E	lealth and		/giene		
Physiciar Medica	1/	Registrar 1. Decedent's Name (First, Middle,	Last) Paul Bryar	n Car			, cairi	2. Date of De Month		2011 9, 2011 ^{Year}	3. Time of Death 2:05 AM
Examine	er		ontgomery Roa			4b. City, Town, or	Location of Dea Ellicott C	ity			oward
Funeral Director		5. Social Security Number 216-20-2293 Usual Residence of Decedent	6. Sex 1 M 2 □ F 7. Ag	ge (In yrs. la 86	st birthday) Yrs.	If Under 1 Year Months Days	rth ay, Year) I 27, 19	9. Birthplace (State or Foreign Country) MD			
Maryland :8a-f show tified at	- 1	10a. State 10b. County	Howard	10c. City	, Town or Loc	eation	Ellicott C	City			10d. Inside City Limits 1 Yes 2 No
with the Ns 23a or 2	Funeral Director	10e. Street and Number 5431 Montgomery I	Road			10f. Zip Code	21043		10g. Cit	tizen of What Coul	•
	ह	1. Marital Status 1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? ed 1 1 1 Yes 2 1 If Yes, Give Year or Dates.			Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 ☑ No		Specify Yes or No to Rican, etc.)	-	14. Race - Americ Black, White, Specify: W	
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", only injury or other traumatic event, the Medical Example.	Completed	15. Deceden (Specify only highes Elementary/Seconday (0-12) 12		5+)	(Give F	ent's Usual Occup: ind of work done o O NOT use retired) Moc	ation luring most of wo lel Maker	orking	16b. K	ind of Business In	dustry
yland 2 Id be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Charles Augustus Carter 18. Mother's Name (First, Middle, Maiden Grace Ev									n
hd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationshi Shirley Carter Sp				g Address (Street a					Code)
timore Page 1 a ment of H tant: If ite		20a. Method of Disposition 1 Surial 2 □ Cremation 4 □ Depation 5 □ Other (Sp	pecify)		emetery, crem St. John's	sition (Name of latory or other place Lutheran Ch	urch O	Date ct 22, 2011			own, State
Balt permit Depart Impor any in		21. Signature di Fundral Service Li	fle mou			Name and Addres Slack F 3871 OI				/ID 21043	
ii iii 6	ical Examiner	and 1. Enter the discusse, or a shock, or heart failure. List or humediate Cause (Final sease or condition resulting in death) Sequentially list conditions, if any, leading to municulate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	aDue to (or as	a consequ	ence of):	Harr		EI C			Approximate Interval Between Onset and Death
Box 68760 The death certificate be the attending physiciched for use as the bu		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	Ideath 3 🗌	Ectopic pregnanc Other (specify)	у			23d. Date of deliv Month	ery Day Year
ords, P.O. Be requires that the de been signed by the should be detached	ted by Pr	Part II. Other significant condition	ns contributing to death to	/ /	ulting in the u	nderlying cause giv	en in Part I.				he cause of death?
Record The law rectate has been	Complet	1 Club Fail	url					24a. Was auto perf 1 \square Yes		prior to co death?	psy findings available impletion of cause of 2 No
of Vital ng Physician: fter this certifi	To Be	25. Was case referred to medical examiner? 1	28a. Date of inju (Month, Da ation	ury y, Year)	ER/Outpatien 28b. Time of injury me, farm, stre	t 3 DOA Other	4 ∐ Nursing at	Home 5 Res 28d. Describe	how injur	☐ Other (Specify y occurred d Number or Rura	
Divi	Medical Ce	29a. Certifier 1 Certifying	Physician: To the best of	my knowl	edge, death o				ause(s) ar	nd manner as state	
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu			caminer: On the basis of a Nurse Practioner: To the	best of my	knowledge, c	eath occurred at the 29c. License	time, date and p	lace, and due to t	he cause(s 29d. Da	s) and manner as st te signed (Month,	tated. Day, Year)
7		٥٩١١١١١ ٢١٥	ROSS, M.D.	death (Item	23a) (Type, P	rint) SRSEY WI	ALL DR,	Su/18	201	844100	2011 77 C174, MD
State Registra DHMH 17 Rev 7/200	r	31. Date filed (Month, Day, Year) OCT 2 7 201	82 Registr	ar's Signat	fack				_		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

(evin Vernon (Sraw	ey, Sr. Stat 1-For State Registrar	e of Marylan		tment of <i>ificate of</i>		Mental		eg. No. 20	11 3426
Physic		1. Decedent's Name (First, Middle,L						2. Date of Dea Month		3. Time of Death
Medical Exan	niner	Kevin Vernon Cr 4a. Facility Name (if not institution, s		_		4b. City, Town, or I	eastion of Do	October 2	3, 2011 4c. County of De	1030 hrs
,		800 Block of Borchers L		61)		Baltimore	Location of Dea	auı	n/a	
Funera Directo			Sex 7	Age (In yrs. Ias	et birthday) Yrs	If Under 1 Year Months Days		lin	rth (MM/DD/YYYY) 9. 3 / 1 9 6 1	Birthplace (State or eign Country) MD
yne	1	Usual Residence of Decedent 10a. State 10b. County		10c City T	own or Locat	ion				10d. Inside City Limits
*		MD n/	a			Baltimo	re			1 Yes 2 No
Aaryland 28a-f show	Director	10e. Street end Number	10f. Zip Code					1	0g. Citizen of What C	ountry?
th the Maryland 23a or 28a-f sho	Ϊ́	2302 East Chase					218		USA	
15-0036 filed within 72 hours after death with the Maryland 1 Hygiene. ed other than "matural", or items 23a or 28a-f ah the Medical Examiner mut he notified at ance	Funera	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce	1 Yes ed If Yes, Give Year	ent Ever in U.S es? 2 No	lf Y	is Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, Pue		o- 14. Race - Am White, etc	
ours at	d by	15. Decedent's Education (Specify	only highest grade of	completed)	16a. Deceden	it's Usual Occupati	on (Give kind o		16b. Kind of Busines	
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natur cerent, the Medical Exam	Completed	Elementary/Secondary (0-12) 9th	College (1-4	,	_	endent Co	ntracto	or	Home Impr	rovement
215-1 e filed real Hyg ked oth	Be	17. Father's Name (First, Middle, La Douglas Crawley]		me (First, Middle, 1 Elaine S	Maiden Surname) Smith	
	10	19a. Informant's Name/Relationship	(Type, Print)				and Number of	r Rural Route Nur	mber, City or Town, St	
e, MD 1 and 2 shou Health and 1 item 27 is referred.		Avis Hall- Frie	nd	20b Pi	<u> </u>	East Cha		Date Date	, MD 21218	
Baltimore, Remit. Pages I and Department of Healt Inportant: If item injury or other framining to the properties.		1 XBurial 2 Cremation	_	State Cre	ematory or other			.31.2011		
Baltimord permit Pages I Department of I Important: If		4 Donation 5 Other Speci 21. Signature of Funeral Service Vice				-			Directors,	· ·
		18 9. W.		}	45	ol/ Park .	<u>Heights</u>	avenue .	<u>Baltlmore</u>	MD 21215
Physician /M		23a. Jah I. Enter the disease, or con failure. List only one cause on	each line.			he mode of dying, :	such as cardia	c or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
examine		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	Injur:						Beaut
	L	Sequentially list conditions,	b							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Discass or injury that initiated	Due to (or as a co	nsequence of):		-31 -3				
ted I	Ex	events resulting in death) Last	Due to (or as a co	nsequence of):						
iO, e be executed ysician and burial - transit	edical	x UNPENDED		3a,pt.I	1,27,2	8a-f per	me g92	22 12-7-1	ll vt	
Il Records, P.O. Box 68760, In: The law requires that the death certificate be ex- rificate has been signed by the attending physician or, page 2 should be detached for use as the burial.	₩ W	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, out			<u></u>	-		23d. Date of deliv	
Box 6876 e death certificate the attending phy ed for use as the le	cian	past 12 months?	1 Live birth 4 Pregnant	at time of deat	, - H	tal death 3 [her (Specify)	Ectopic preg	nancy	Month	Day Year
D.O. BO) that the death ned by the att detached for	Physician/M	1 Yes 2 No 9 Unknow	a Cukuowu		0.					
P.O.		Part II. Other significant condition Heroin and Co			ulting in the u	ınderlying cause gi	iven in Part I.			to the cause of death?
cords, Paw requires that has been sign 2 should be o	170	102020 00					•	24a. Was		autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death. Divector: After this certificate has been is led in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	d E								proprint prior to pri	
tal Rec sian: The l certificate l	Becc	25. Was case referred to medical				26.Place	of Death (Ched		2 10 1	763 2 110
F Vital Physician: r this certifi	1º	examiner? 1 ✓ Yes 2 No			R/Outpatient				Residence 6 Ot	her: Scene
on of onding Ph. th. The After the funeral	io iii	27. Manner of Death 1 Natural 5 Pending	28a. Date of I (Month, Da	y,Year)	28b. Time of I	1 ¬v	yatWork? es 2 x No		how injury occurred	
visic r Atte ter dea lirector	ficat	2 Accident Investig	28e Place of		fd 1028 ne, farm, stree	et, factory, office bu			Street and Number or	Rural Route Number, City
Divinal of ours af theral Divined i	Certification:	4 Homicide determin		outs	ide-al	ley		or Town, S Lane	Baltimore,	. Borchers
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		(se(s) and manner as s and place, and due to	
Tot Tot	Medical	29b. Signature and title of certifier	and manner state			29c. License		_,	29d. Date signed (
		Churc	11>	4	-	O.C.N	Л.E.		October 24, 20	011
		30. Name and address of person wh			-			MP 0/22	<u> </u>	
V	\\		sistant Medical	trade Signature			et, Baltimor	e, MD 21223		
Regi	State strar	nct 27 20		, a s signatur	bar	Kal				

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Month 18:57 PM 24 201 ROBERT SCOTT CHINN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore None Union Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 01*/*15/1951 Texas Yrs. Director 022-42-0611 60 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Baltimore XX Yes 2 No Maryland None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 4100 North Charles Street # 1103 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 ☐ Married Page 1 and 2 should be filed within 72 hours after Yes 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hotel Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Brian Chinn Barbara Houghton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau 4100 North Charles Street #1103 Baltimore, Maryland 21218 Barbara Chinn Newbauer Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 10/27/2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Death Immediate Cause (Final Ph. sician/ retention secondary to decreased respirations 0 minutes disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 2 X No 1 🗌 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other 1 ☐ Yes 2 🗷 No 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, neral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 5 Pending 2 🗆 No 2 Accident
3 Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifie 10/24/2011 1720379951 address of person who completed cause of death (Item 23a) (Type, Print) - 201 E. University PKWy - Union Memorial Hospital Baltimore MD

Registrar DHMH 17 Rev 7/2009

State

Yaghi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34262 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ tober a M Kenneth O. Danz 201 Medical 4a. Facility Name (if not institution, give street and numbe 4c. County of Death **Examiner** 4b. City, Town, or Location of Death maryland Baltimure General If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1**x** M 2 □ F Hours Country) Director 75 Yrs Un's. 494-36-8804 1936 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21201 United States 804 Cathedral Street, #13 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Completed by 1 😾 Never Married 2 🗆 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 TyNo Specify. Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Editorial** unk Copywriter Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Rutherford / Friend 15 Austin Rd., Reisterstown, Maryland 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Metro Crematory Inc. | 10/26/2011 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant of time 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been s ; page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' Yes 2 this certificate 2 \square No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending after death

Director: A

I in by the fi 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direc completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title of certifier

Date filed (Month, Day, Year,

OCT 27

Dame and address of person who completed cause of death (Item 23a) (Type, Print)

Ama Vunnoym, MI) 40 mary land Greneral Hospital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert E. Frye 7:40 P M Oct<u>ober</u> 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs 5. Social Security Number Funeral 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Months 1 MM 2 🗆 Aug. 10 Year 1942 Maryland Director 69 218-38-6759 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified Prince George's 1 Tes 2xXNo Lanham 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be I 23a 7123 Forbes Blvd. 20706 U.S.A. an "natural", or items Medical Examiner mu 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XX Yes 2 No Army
If Yes, Give Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 af Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Small Fuse Company 12 Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file of Mental ည Unknown Ruth Frye and Is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Diane A. Frye - Wife 7123 Forbes Blvd., Lanham, MD 20706 permit. Page 1 and 2 Department of Healt Important: If item 2 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Parklawn Memorial any injury Gardens 10-28-2011 Rockville, MD Signatule of Funeral Se 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner uma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a or nsequence of a the burial-transit Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE use yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ ō in the past 12 months? 1 Yes 2 9 Unknown the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying eause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ mimorary Records, 1 Tyes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy MAVV 0 10 of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiller? ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 injury OOM 1 Natural
2 Accident 5 Pending work? Division I hours after death. uneral Director: Af ed filled in by the fu JeTo bell, 2 Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 28f. Location (Street and Number or Buray Proute Number, City or Town, State) determined home To the Hospital within 24 hours a To the Funeral D completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certiff 29d. Date signed (Month, Day, Year) 25/1 0043662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr. Chevery, MD 20785 ZOUR State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 34264 1- For State Certificate of Death Registrar Rea. No Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death Murdis Da Medical Examiner Ferguson Year 1710 hrs October 17, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital ICU Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 214-64-5321 Director Months Days Hours Country)SC 1 M 2 🔀 F 56 June 30,195 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2614 Lauretta Avenue 21223 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No 1 Ves Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify <u>გ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Black and Baltimore, MD 21215-0036 12th Laborer N/A Decker Corp. 17 Fathers Name (First, Middle, Last) Clifford Ferguson 18.Mother's Name (First, Middle, Maiden Surname) Emma Johnson Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaTonya Ferguson/Daughter 2614 Lauretta Ave. Balto., MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place)
Zion Cem 0/29/11 Lansdowne, MD Donation 5 Other Specify 21 Signature of Funeral Service Licensee 22. Name and Address of Facili Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Immediate Cause (Final disease a Intraparenchymal Hemorrhage & cocaine use ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED AMENDED 23a, 27, per me, g921 11-21-11 sm e attending physician for use as the burial Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy past 12 months? 2 Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ✔ Unknown **Director:** After this certificate has been ad in by the funeral director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed1 death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical Division of Vital Be 26.Place of Death (Check only one) examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 28f. Location (Street and Number or Rural Route Number, City 6 Could not be or Town, State) 4 determined Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OCME** O.C.M.E. October 18, 2011 who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD. 32. Registrans Signature State

DHMH 17 Rev 1/2001

Registrar

Medical

(0,200.1) 1.19 1.19		life. DO NOT use retired]	9					
Elementary/Seconday (0-12)	College (1-4 or 5+)	farm			dairy				
7. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	iden Surname)				
Ralph G. Flanaga	an		Este	ella Wach	nter				
19a. Informant's Name/Relationship (19b. Mailing Address (Street	and Number or Rura	al Route Number, C	City or Town, State, Zi	p Code)			
Pauline T. Flanag	gan/ wife	7401 Willow	Rd., #257	Frede	erick, MD	21702			
20a. Method of Disposition		lace of Disposition (Name of emetery, crematory or other pla	ce) [Date 2	0c. Location - City or	Town, State			
1 ☐ Burial 2 🔀 Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	_ nemoval nom state	L County Cremat			Sykesvil:	le, MD			
21. Signature of Funeral Service Licer				rtzler Fi	neral Hom				
1 (athanie	O. Harle	√ 404 S. Ma			, MD 2179				
23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)			ng, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence) d.	ience of):							
F FEMALE: 33b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of c	al death 3		23e. Did toba	23d. Date of de Month	elivery Day Year o the cause of death?			
				1 ☐ Yes	s 2 🗆 No 3 🗆 F	Probably 4 Tunknown			
				24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of			
25. Was case referred to medical examiner?		26. F	Place of Death (Check						
1 Yes 2 No	Hospital:	ER/Outpatient 3 DOA Oth	ner: 4 Nursing Ho	ome 5 Resider	nce 6 Other (Spe	cify)			
7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigati	28a. Date of injury (Month, Day, Year)	28b. Time of injury 28c. Inju wor 1	ry at k? Yes 2 No	28d. Describe how	v injury occurred				
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	be Place of Injury - At he	me, farm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,			
(Check 2 Medical Example 1)	ysician: To the best of my knowl miner: On the basis of examination urse Practioner: To the best of my	and/or investigation, in my opin	ion, death occurred at	t the time, date and	place, and due to the	cause(s) and manner state			
29b. Signature and title of certifier	um	29c. Licens	se number	29	d. Date signed (Moni	th, Day, Year)			
80. Name and address of person who A. めいかをしらっへ	MD 65 C	THOMAS V	otheson	de	FLEDER	ICK, MDZ11			
OCT 2 7 201	32. Registrar's Signar	facke							
		ORIGINAL							

Registrar DHMH 17 Rev 7/2009 34265

2:05 P M

State of Maryland / Department of Health and Mental Hygiene 2 1 For State Registrar

4a. Facility Name (if not institution, give street and number)

Wachter

Homewood at Crumland Farms Hlth. Ctr.

1. Decedent's Name (First, Middle, Last)

Bernard

Certificate of Death

4b. City, Town, or Location of Death

Frederick

21702

Min.

Flanagan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No. 2. Date of Death

8. Date of Birth (Month, Day, Year) May 27, 1920

October

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 🗌 Yes 2 🔀 No

Maryland

White

2011

Frederick

4c. County of Death

10g. Citizen of What Country?

Specify.

16b. Kind of Business Industry

U.S.A.

14. Race - American Indian, Black, White, etc.

Physician/ Medical **Examiner**

Funeral

Hospital or Attending Physician: The law requires that the death certificate be executed ours after death. Jeral Director: A filled in by the fi

State

To the within 2 To the F

Ernest Bo Gales III 11-07876

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

•	2	0		3	4	2	6	6

nk Unk	1-1	State of Maryl For State		ate of Deat		Reg	No			
	Re	glstrar Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death		
Physician/ ical Examiner			30	Gale	s III	Month Cotober 19,	Day Year 2011	2251 hrs		
Out Exertise		rnest a. Facility Name (if not institution, give street and r	umber)	4b. City,	Town, or Location of	Death	4c. County of Dea			
		8137 Salt Lake Drive		Wind	Isor Mill		Baltimore County			
Funeral	5.	Social Security Number 6. Sex	7. Age (In yrs. last bir	,,	der 1 Year If Under	Min	(MM/DD/YYYY) 9. B Fore	ign		
Director	2	18-27-8717 1XM 2 F	21	Yrs.	ns Buys Troute	01 29	90 0	ountry) MD		
	_	sual Residence of Decedent	10c. City, Town	or Location				10d. Inside City Limits		
w any	10	Da. State 10b. County		altimor				1 Yes 2 No		
faryland 28a-f show 1 at once. ector	<u> </u>	MD NA	В		p Code	100	a. Citizen of What Co	untry?		
the Maryland or 28s-f sh tiffied at once		De. Street and Number		101. 2.	21244		U.S.A	_		
		303 Northmont Road Marital Status 12. Was D	ecedent Ever in U.S.	13. Was Deced		n? (Specify Yes or No-	14. Race - Ame	erican Indian, Black,		
r death with or items 23 must be no		Never Married 2 Married Armed	Forces?	If Yes, spec	ify Cuban, Mexican,	Puerto Rican, etc.)	White, etc.			
F. or T		X 1 Yes Widowed 4 Divorced If Yes, Give Y or Dates:	ear	_	No specify:			lack		
urs aft		15. Decedent's Education (Specify only highest gr	ade completed) 16a	Decedent's Usua	I Occupation (Give ki	ila or morri acris	16b. Kind of Busines			
72 hours as "natu		2.07,10.11.11.7	(1-4 or 5+)		nance Ass		Genesis Care	пеатсп		
5-0036 ed within 72 tygiene. other than the Medical		2th grade ly				Name (First, Middle, M				
Hyger He		7. Father's Name (First, Middle, Last) Ernest Gales Jr.				nice Payne				
21215-0036 ould be filed within 7 the Mental Hygiene. s marked other than ite event, the Medical To Be Comple	-	9a. Informant's Name/Relationship (Type, Print)	11	9b. Mailing Addres	ss (Street and Numl	oer or Rural Route Numl	per, City or Town, Sta	ite, Zip Code)		
MD 21 dd 2 should dith and Men m 27 is man aumatic ev	_	4r.& Mrs.Gales-Pare				Road, Bal				
e, N and J Health item		20a. Method of Disposition	20b. Place	of Disposition (Natory or other place	ame of cemetery, e)	Date	20c. Location - City	or Town, State		
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is me injury or other traumatite	- 10	1 Burial 2 Cremation 3 Remova 4 Donation 5 Other Specify:	HOIH State	odlawn		10/29/201	l Woodla	wn, Md		
litin nit. P artme sortar	2	21. Signature of Funeral Service Licenses		22. Name ar	nd Address of Facility	st				
E. F. Der	1	Blynn B. The	K	4300	Wabash	Ave, Balt		d 21215 Approximate Interval		
- Physician	72	 art I. Ent. r he disease, or complications of follure. List only one cause on each line. 		not enter the mod	e of dying, such as ca	ardiac or respiratory arre	St, Shock, of rieart	Between Onset and Death		
/Medical ≟xaminer		Immediate Cause (Final disease a. Multiple (Sunshot Wounds					Deali		
_Admino.	- '	or condition resulting in death) Due to (or a	s a consequence of):							
		Sequentially list conditions, if any, leading to immediate Due to (or a	s a consequence of):							
ted Insit		cause. Enter Underlying Cause (Disease or injury that initiated	s a consequence of):							
ed nsit	EX	events resulting in death) Last Due to (or a	s a consequence or).							
xecut m and ul - tra	edical	UNPENDED AMENDE	D							
cash certificate be executed attending physician and for use as the burial - transit		IF FEMALE: 23c. If ye	s, outcome of pregnance				23d. Date of deliv			
rtifica ing pl	2 au	3b. Was decedent pregnant in the	e birth	2 Fetal dea		pregnancy	Month	Day Year		
DX 6 ath ce attend or use	Sici	4 P	egnant at time of death known	5 Other (S	pecify)					
Division of Vital Records, P.O. Box 68760, ta or Attending Physician: The law requires that the death certificate be executed as after death. 1-1 Director: After this certificate has been signed by the attending physician and lited in by the funeral director, page 2 should be detached for use as the burial - transition in the content of the content	Physician/N	Part II. Other significant conditions contributing		ting in the underly	ing cause given in Pa			to the cause of death?		
P.O. s that s that gened the deta	<u>a</u>					1 Yes	2 V No 3 F	robably 4 Unknown		
ds, equire een si ould b	Completed					24a. Was autop		autopsy findings available to completion of cause of		
COT law r	톍						med? death	1?		
Re ificate		25. Was case referred to medical			26.Place of Death					
Sician sician is cert lirecto	o Be	examiner? 1 ✓ Yes 2 No	Inpatient 2 ER	/Outpatient 3	DOA Other	Nursing Home 5	Residence 6 🗸 0	ther: Scene		
of V g Phy frer th neral c	⊢ -	27. Manner of Death 28a. D	onth Day Veer)	b. Time of Injury	28c. Injury at Work	Subject sho	how injury occurred			
OD (cadin	흷	Pending Oct	9, 2011 22	OUND: 229 hrs	1 Yes 2 ✔	No ,		Other City		
ViSi or Att frer de in by :	Ę	2 Accident Investigation 3 Suicide 6 Could not be	Place of Injury - At home	, farm, street, fact	ory, office building, e	or Town S	State)	Rural Route Number, City		
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Fuceral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical Certification:	4 Homicide determined (Spec	ify) In vehicle				e Drive, Windsor I			
e Hos	gal	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the ba	best of my knowledge, sis of examination and/	death occurred at or investigation, in	the time, date and pl my opinion, death of	ace, and due to the caus ocurred at the time, date	se(s) and manner as and place, and due t	o the cause(s)		
To the within To the comple	ed	and manr	er stated.		29c. License number		29d. Date signed			
	2	29b. Signature and title of certifier)		O.C.M.E.		October 20, 2	011		
/ /		20 Jame in address of person who completed	rause of death /Item 23	a)						
Ó V │		Laron Locke MD. Assistant Med	lical Examiner 9	00 W. Baltim	ore Street, Baltii	more, MD 21223				
Sta	ate		2. Redistrar's Signature							
Registr		OCT 2 7 2011	Semina 1	back						
DHMH 17 Rev 1/20	001	OCME	70	ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State o	f Maryland / De <i>C</i>	partment of H ertificate of D			ene g. No. 201	1 34267		
Ė	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death October		3. Time of Death		
	Medic Examin	al .	Ora Analyn Gr 4a. Facility Name (if not institution, give street and num	aham ber)	4b. City, Town, or	Location of Death	October	4c. County of Deat	9:50 A M		
	Examini		Golden Living Center		Wes	tminster		Carroll			
	Funeral Director		218-32-9125	7. Age (In yrs. last birthda 91 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y DeC • 1	9. Birthplace (State or Foreign Country) Virginia			
	and show i at	o	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits		
	Maryla 28a-f otifiec	Director	Maryland Carroll		ndsor			1 X Yes 2 □ No			
	/ith the 23a or st be n	ral D	10e. Street and Number 302 College Ave.	og. Citizen of What Co ${f U}_ullet$	S.A.						
	death v items ner mu	Funeral	11. Marital Status 12. Was Dece		Was Decedent of His If Yes, specify Cubar	21776 spanic Origin? (Spen, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
39	al", or	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 🔀 Widowed 4 ☐ Divorced Year or Da	Э	1 ☐ Yes 2 🕱 No	Specify:		Specify:	White		
2-0	2 hours "natur edical I	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Occupa		ng 1	6b. Kind of Business	Industry		
21215-0036	filed within 72 hours after death with the Maryland all Hygiene. All all Hygiene dother than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Com	Elementary/Seconday (0-12) College (1-	4 or 5+) life	e. DO NOT use retired) cook			restaur	ant		
nd	e 1 and 2 should be fled within 72 hours after death with the Maryland to fleath and Mental Hygiene. It heath and Mental Hygiene. If them 27 is marked other than "natural", or items 28a or 28a-f show if ther traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	····	-		e (First, Middle, Ma	aiden Surname)			
Maryland	should be file and Mental is marked of aumatic eve	-	John Loftice 19a. Informant's Name/Relationship (Type, Print)	19b M	ailing Address (Street a		ice Neff	City or Town, State, Zi	p Code)		
	id 2 sh aalth ar n 27 is er trau		Ronald J. Graham/ son	4.	College Av			or, MD 217			
ore	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from	State cemetery, of	sposition (Name of crematory or other place	e) i		20c. Location - City or			
altimore,	3 F P S	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Meadow	Branch Cem 22. Name and Addres			Vestminste neral Home			
m	Depar Impor any in	- 1	Marine V. Har	Bler	310 Church			sor, MD 21			
	MINIMA CAR		23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on pa Immediate Cause (Final	ch line.	1	\			Approximate Interval Between Onset and Death		
	disease or condition resulting in death) Due to (or as a consequence of):										
	Examiner	er	Sequentially list conditions, b.	prasequence of):	olic Vero	ern	Vac Tital		25 70		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	world	age				919		
	tate be executed physician and the burial-transit		resulting in death) Last Due to	or as a consequence of):					_		
3760	ficate b g physi as the k	Nedical	d								
.x 68	ath certifica attending p	Physician/M	in the past 12 months?	come of pregnancy Birth 2 Fetal death		у		23d. Date of de	elivery Day Year		
. Box	he deat y the at iched fo	hysic	1 Yes 2 No 4 Preg 9 Unknown 9 Unknown		5 U Other (specify)			World			
Records, P.O.	requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to d	eath but not resulting in the	ne underlying cause giv	en in Part I.			o the cause of death?		
ords	require been si should	leted					24a. Was an	24b. Were au	utopsy findings available		
3ec	nysician: The law nis certificate has b I director, page 2 s	Completed					autopsy perform 1 Ves 2	y prior to death?	completion of cause of		
ta	ician: Sertifica ector, p	Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No Hospital:		_ Oth	ace of Death (Chec					
of V	g Phys er this c eral dir	e: To	27. Manner of Death 28a, Date	Inpatient 2 ER/Outpa of injury 28b. Tim th, Day, Year) inju	e of 28c. Injury	4 Æ Nursing Ho ∕at	ome 5 Resider 28d. Describe hov	nce 6 Other (Spe w injury occurred	cify)		
ion	tending leath. tor: Aft the fun	Certificate:	2 Accident Investigation		M 1 🗆	Yes 2 No			15 1 November		
Division of Vital	al or Attendi s after death I Director. A d in by the fi		4 Deminide determined 28e. Place	of Injury - At home, farm, ng, etc. (Specify)	, street, factory, office		City or Town,	eet and Number or Ru State)	urai Houte Nurriber,		
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base of the control of the base only one) 1 Certifying Nurse Practioner:	sis of examination and/or in	vestigation, in my opinio	n, death occurred a	t the time, date and	d place, and due to the	cause(s) and manner stated.		
	To the comp	2	29b. Signeture and title of certifier Yourn W. Mullls		29c. License			9d. Date signed (Mon			
P			30. Name and address of person who completed caus	se of death (Item 23a) (Typ	pe, Print) Posto Rd	1 13		101401	E //		
t٧			Idhney Middleton	MD 688	Pedle Rd	West	nin ster	, MD 2	1157		
	Sta Registr		31. Date filed (Month, Day, Year) 32. F	legistrar's Signature	Red						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 34268 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year Physician/ Glorioso Ida Η. : 45 . Medical 2011 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford BelAir BelAir Health & Rehab. Center . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year **Funeral** Days Hours Min. Director 1 M 2 X F 217-09-8007 9-26-20 Maryland or 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location by Funeral Director must be notified BelAir 1 Yes 2 X No Harford MD 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a 410 E. Macphail Road 21014 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. ō Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White "natural", 3 ₩ Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home of Health and Mental Hygitem 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ George J. Lubin Ida F. Pailor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Glorioso -Son Andrews Way BelAir, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🛣 Cremation 3 🗌 Removal from State 10-27-11 4 Donation 5 Other (Specify) Greenmount Crem. | Baltimore, Md. 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. Signature of Funeral Service Licenses Conkling St. Baltimore, Md.21224 263 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ecus Medical Due to (or as a consequence **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the business. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Vear Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 510 1 Yes 2 70 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Division Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Fxamper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of dertifier 21040 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ james 10:00 AM Ganes Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2822 Edgecombe Circle 21215 U.S.A. 5. Social Security Number 217–38–7037 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Days Min. (Month, Day, Year) **Director** 1 JM 2 🗆 F 69 08/24/1942 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 2822 Edgecombe Circle 21215 U.S.A. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐KNo Specify: Specify: Black and Mental Hygiene. 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 11th Grade College (1-4 or 5+) Pipefitter Cotten Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wesley Gaines Bertha Ferguson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 1223 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health item 27 Erika Gaines(daughter) 1330 W. Lombard St. Unit 3, Baltimore, or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest 11/02/11 Owings Mills, 36 September of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, I 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Physician: The law requires that the death certificate be Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 No Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 X Yes 2 No 3 Probably 4 Unknown should Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? Coronary Artery Discase certificate Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 😿 No မ 1 Tyes 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 Yes 2 No 1 X Natural 5 Pending injury eral Director: A 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 00035363 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 BVAMC Greene St. Marshalmo 10 N.

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

26

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month & 83c ARNEST **Medical** 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death RANDALLSTOWN Baltimore Season's Hospice 5. Social Security Number 1 Year I If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under **Funeral Director** 97 264-22-1817 1**X** M 2 □ F 04 09 14 GA Usual Residence of Decedent 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 □ No MD NA 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be i Funeral West Garrison Avenue 21215 U.S.A. 2819 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Crown Cork and the Seal 12th grade Custodian 8yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ Sahar Hall Lukellen Humphrey other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st
Department of Health ar
Important: If item 27 is, Valarie H. Scott-Niece 2819 West Garrison Ave, Baltimore, Μd 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 10/29/2011 Laurel, f Funeral Service Licemee March F/H West 4300 Wabash Av Baltimore, Md Wabash Ave, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Imprediate Cause (Final Ph sician/ ease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami or Attending Physician; The law requires that the death certificate be executed and -trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No 9 Unknown Unknown signed by the P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 2 🗌 No 1 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? nos Hospital Other: 1 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at work? 28c. 28d. Describe how injury occurred hours after death. Ineral Director: After Natural 5 Pending injury filled in by the Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier se of death (Item 23a) 🕼 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1244 AM Physician/ HICKIES nzell 10 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Secours Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. (Month, Day, MARVIAND Director Usual Residence of Decedent or 28a-f show notified at 10d Inside City Limits 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No MD 10g. Citizen of What Country? 10e. Street and Number ö er than "natural", or items 23a or the Medical Examiner must be r Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Register of and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PARALEGA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Page 1 and 2 should I nent of Health and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 2 /3 23 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau. BALTIMURE, MARY AND
ate 20c. Location - City or Town, State TOMICINA MURPHY *l*mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LANSdOWNE, MARYLAND 21. Signature of Funeral Service Vicensee 22. Name and Address of FATTINE DERRICK C. JONES FII+, P.A. Approximate Interval Between Onset and Death AVE. BALTIMORE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or s a confequence of): -Ph_lician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of): the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Directors this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burner burners. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ☐ Pregna... ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 WUnknown Division of Vital Records, 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 29d. Date signed (Month, Day, Year) D0063545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year)
OCT 2 7 20 State

OHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 25 201^{Year} 7:21 Virginia Leigh Hamilton Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Carrol1 Westminster 5. Social Security Number 6 Sex 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day,
Dec. 27 9. Birthplace (State or Foreign Country) Indiana 7. Age (In vrs. last birthday) If Under **Funeral** 1 □ M 2 💢 F 1927 **Director** 83 308-26-6217 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 X No Maryland Carrol1 Westminster 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 30 Locust Street 21157 United States items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian. Black, White, etc. ò 1 Never Married 2 Married hours after þ Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify and Mental Hygiene.
is marked other than "natural", White Completed 3X Widowed 4 □ Divorced Specify: the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Ralston Pauline Meece 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n any injury or offer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Hamilton / Son 808 Weeping Cherry Ct., Sykesville, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/26/2011 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ P in the past 12 months? Day Year Pregnant at time of death Yes 2 No be detached a | I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has page 2 autopsy prior to completion of cause of death? perform this certificate 2 3 No 1 Yes Yes 2 or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 100 Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home A hours after deatn.

Funeral Director: After th funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and

0 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

leted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

5 5 5 Ù 29d, Date signed (Month, Day, Year)

11-07710	
Eric Johnson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Johnson		1- For State	ate of Maryla	•	artment of rtificate of		and	Menta	al Hyg		eg. No.	20		3427
Physicia dical Examin	ın/	Registrar 1. Decedent's Name (First, Middl Eric	_{e,Last)} Johnson							Date of Dea Month October 1	ith	Year	3	3. Time of Death 1938 hrs
		4a. Facility Name (if not institution 1554 Boyle Street	n, give street and nu	umber)	4	b. City, To		ocation of I		october 1		County of D	eath	
Funeral Director		5. Social Security Number 108-60-1366	6. Sex	7. Age (In yrs.	last birthday) 34 Yrs.	If Under Months		If Under 2 Hours	24Hrs. 8 Min.	3. Date of 8ii 2/6/). Birthp Coun	place (State or Foreign
land f show any once.	tor	Usual Residence of Decedent 10a. State 10b. County 10b. N/A			Town or Location	9								0d. Inside City Limits 1 Yes 2 No
ith the Maryland 123a or 28a-f show s notified at once.	Director	10e. Street and Number 1554 Boyle S	treet			10f. Zip C 212					0g. Citiz US	en of What A	Countr	y?
r death w	by Funeral	3 Widowed 4 Div	arried Armed F 1 Yes orced If Yes, Give Yes or Dates:	2 X No	1	es, specify Yes 22	Cuban, N	Mexican, P	uerto Rio			White, e Specify: E	tc. Bla	
imore, MD 21215-0036 Pages I and 2 Nould be filed within 72 hours after near of Health and Mental Hygiene. Instr. If item 27 is marked other than "natural", or other traumatic event, the Medical Examine.	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12th	College (16a. Decedent during mo	st of worki	ng life. D ch .	O NOT us	se retired)	Un Ce	nter		_{dustry} y Medical
21215-0 21215-0 21215-0 I Mental Hygic marked othe	Be	17. Father's Name (First, Middle, Edward C. Ha	rrison					Luci.	lle	irst, Middle, John	son			
e, MD 2: 1 and 2 should Health and M item 27 is m: r traumatic e	우	19a. Informant's Name/Relations Helen Benton			19b. Mailing 2927					al Route Nu 2nd		21	.21	8
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other training or other tr		20a. Method of Disposition 1 Burial 2 Cremation 4 Ponation 5 Other St. 21/ Signature of Funeral Service	pecify:				emt.	. 10	0/24		1 в		nor	e, MD North
Physician		23 Part I. Enter the disease, or	Walter	au od the death	Ave	e. Ba	alti	imor	e, N	4D 21	202		<u>.</u> .	Approximate Interval
/Medical Examiner		ailure. List only one cause Interediate Cause (Final disease or condition resulting in death)	on each line. a. End-stage		ase		-yg, 55						2	Between Onset and Death
	er	Sequentially list conditions, if any, leading to immediate	b	a consequence of										
executed an and al - transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence o	of):		-							
o, pe	edical	UNPENDED	AMENDED											
lox 6876 eath certificat eath certificat eattending ph for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unit	1 Live b	nant at time of de	2 Fet	al death er (Specif		Ectopic p	regnancy	<i>y</i>		. Date of de Month	Da	y Year
cords, P.O. Blaw requires that the dhas been signed by the 2 should be detached	<u>چ</u>	Part II. Other significant condit	ions contributing to	o death but not r	resulting in the ur	nderlying c	ause give	en in Part	l.		_			e cause of death?
of Vital Records, ng Physician: The law requir the this certificate has been so meral director, page 2 should l	Completed									1 ✔ Yes	osy rm <u>ed</u> ?	prio dea	r to cor	psy findings available mpletion of cause of
Vital hysician: this certiful director	o Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient		I Ot	f Death (C		y one) Home 5	Resider	nce 6 🗸	Other: S	Scene
ttending Phydeath	-	27. Manner of Death 1 Natural 5 Pend		of Injury , Day,Year)	28b. Time of In			at Work?		d. Describe	how inju	ry occurred		
Division To the Hospital or Attendia within 24 hours after death To the Funeral Director: A completely filled in by the fu	Certification:	4 Homicide deter	d not be mined (Specify)		ome, farm, stree	t, factory, o	ffice buil	ding, etc.	28	f. Location (or Town, \$		nd Number o	or Rura	l Route Number, City
To the Hos within 24 h To the Fun	Medical	(Chock chily	nysician: To the bes minet. On the basis and manners	of examination a	-									
	Ž	29b. Signature and title of certifie	1	RIP	PLÉ ha		icense r					ate signed ber 19, 2		h, Day, Year)
5v		30. Name and address of person Ana Rubio MD. Ass	who completed cau istant Medical I		,	more Str	eet, Ba	altimore	e, MD 2	21223			-	
Sta Regist	ate	31. Date filed (Month, Day, Year), OCT 2 7 20	1 2 32. Re	egistrar's Signat	week	•								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 830 Physician/ OCTOBI N DOL Medical City, Town, or Location of Death Baltimore 4c. County of Death 4a. Facility Name (if not institution, give street and number) N/A **Examiner** Good Samaritian Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs last birthday) Social Security Number Sex. **Funeral** 10 19 ay, Months Days Hours Min. Mississippi 1941 425-74-1114 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County 10a. State filed within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 No N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 1559 Sheffield Rd. USA ural", or items a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status Black, White, etc. Specify:Black 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 If Yes, Gir "natural", 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry Medical 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Rosewood St Hospital permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Cook N/A12th 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Anderson Be 17. Father's Name (First, Middle, Last) 2 Arthur Jack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sheffield Rd. Baltimore, MD 21218 Hilda Jack- Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State OwingsMills, 10/31/2013 Garrison Forest Donation 5 Other (Specify) 22. Name and Address of Facility March F/H 1101 E. North e of Funeral Service Lices Ave. Baltimore, MD 21202 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death un know te Cause (Final Physician/ or condition Medical a in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Exami attending physician and for use as the burial-transit certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for a Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 s has performed' 2 No 1 Yes 24 hours after death.

Funeral Director: After this certificate 26. Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 2 No ္ဝ Yes 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending M Investigation Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hor To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 L only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10 0018230 2011 Dr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHDH 31. Date filed (Month, Day, Year) Registrar's Signa State 27

Registrar

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of De 2. Date of Death Physician/ Month 12:30 PM Louise Jackson 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Levindale Nursing Home Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 1 - M 2/- F Months Min. Hours Country) Director 216-30-9563 84 18 Usual Residence of Deceden items 23a or 28a-f show her must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗷 Yes 2 □ No MA NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2807 Boarman Ave 21215 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian "natural", or iter Black White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No 1 Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Completed Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade Domestic Private na Be should be file th and Mental Hy is mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eddie Harris Frances Harris Lye 1 and 2 sh. Lye 1 and 2 sh. Lye 1 mortant if item 27 is many injury or other 2000. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Jackson-Son ₱400 Lencrest Road, Randallstown, Md 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 10/31/2011 Woodlawn Woodlawn, Md 21. Signature of fluneral Service License 22. Name and Address of Facility, March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

In the List Cause (Final disease or condition

Acute Cardiac event Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine schemic cardiomyopathy 6 months accumulative first expectitions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day P.0. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cardiae arrhythmia with chronic atrial Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown tibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No 1 Yes မူ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending within 24 hours after death. To the Funeral Director; A 1 Yes 2 No Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town. State: Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: T. the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0053928 10-24-2011

State

DHMH 17 Rev 7/2009

Registrar

2434

31. Date filed (Month, Day, Year)

ORIGINAL

AVENUE, BALTIMORE

BEQUM,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURALYA 2434 W. BELVEDERE AVENUE. BAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jeanettie Sullivan Kavanagh October 2011 11:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 722 Green Valley Rd New Windsor Carroll Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Y. July 31, 9. Birthplace (State or Foreign Country)
Washington, DC If Under **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 🕱 F **Director** 218-54-6995 62 1949 Usual Residence of Decedent or 28a-f shov notified at 10a, State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe ms 23a Funeral 722 Green Valley Rd. 21776 U.S.A. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. ö þ 1 Never Married 2 X Married Yes Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 - Widowed 4 - Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) human resources space mfg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ Melvin P. Sullivan Betty L. Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Kavanagh Jr./husband 722 Green Valley Rd. New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Prospect Cemetery 4 Donation 5 Other (Specify) 110/29/2011 nr. Mt. Airy, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signalule of Funeral Service Lice 041 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir as the burial-transi resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ signed by the atte in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has after death.

Director: After this certificate performe 1 🗌 Yes 2 🖺 No 1 ☐ Yes 2 X N Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2/No ည 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 26 who completed cause of death (Item 23a) (Type, Print) 21157 Rajpara 224 Washington Hots. Medical Ctr.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day

parke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Yani Kariofili October 2011 6:58 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. Director 579-68-8288 78 November 10, 1932 Turkey Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Silver Spring 10e, Street and Number ō 10f Zin Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 12510 Winexburg Manor Drive, 20906 Turkey hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Med once. Apex Elementary/Seconday (0-12) College (1-4 or 5+) 12 Optical Display Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Konstantinos Kariofili Maria Oikonomidou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katina Pelivanis/Friend 6303 Mt. Branch Court, Bethesda, Maryland 20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) October 26. 20c. Location - City or Town, State 1 🔲 Burial 2 🙀 Cremation 3 🗆 Removal from State Montgomery Crematorium, 2011 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Tnc Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 7557 Wisconsin Avenue 10 M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ HYPERKALEMIN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has k performed2 Yes 2 No 2 0 Ro 1 Yes Be B Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🗷 No Other: Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No Accident 1 🗌 Yes Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one) 29b. Signature and title of certifier 20057129 so, ins 10154141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Troung Bao, MD 10110 Molecular Drive, #206, Rockville, Maryland 20850

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_ For	State of I	Maryland	d / Depa	rtment of H	lealth :	and M	lental Hy	giene	Э		
		State Registrar			Cer	tificate of E	Death			Reg. No	0.201		34278
Physicia		Decedent's Name (First, Middle, La HELEN	,	KOSAK	OWSKI				2. Date of Dea Month OCTOBE		2 ³ ,201	_r 1	3. Time of Death 8:20P M
Medic Examine		4a. Facility Name (if not institution, giv			011011	4b. City, Town, or	Location of		301011		c. County of De		0.201
rad.	44	635 S. Lakewoo				Ва	1tim	ore	City		N	/ A	
Funeral Director			Sex 7. / □ M 2 🗶 F	Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Jan 7	y, Year)		Countr	ace (State or Foreign y) yland
ind show at	è	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Loc	ation				<u> </u>		10	d. Inside City Limits
Maryla 8a-f s	Director	Md.		Ba	ltimo	re City							1 😾 Yes 2 □ No
the last and a series		10e. Street and Number				10f. Zip Code				_	itizen of What		,
h with	Funeral	635 South Lake	wood Ave	enue		2122	4				U.S.	Α	•
336 s after c al", or	ক্র	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	S? No	If	as Decedent of His Yes, specify Cubar ☐ Yes 2X No	n, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wi Specify: W	nite, et	c.
5-C 2 hou "natu	plet	15. Decedent's 8 (Specify only highest gi				ent's Usual Occupa		of working	la la	16b. k	Kind of Busines	ss/Indu	ustry
121 thin 7 sne. than the Me	Completed	Elementary/Secondary (0-12)	College (1-4 o	r 5+)	life. DO	NOT use retired)	_		9		Own	Uot	m.o.
d 2 ed wi Hygie other ent, ti	a l	6th 17. Father's Name (First, Middle, Last)			п	ome Mak		ar'e Name	(First, Middle, I	Maiden		поі	iie
l be fill lental	~ 1	Michael Szyma	nski						ine K <i>a</i>		,		
Baltimore, Maryland 21215-0(permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I		19a. Informant's Name/Relationship (1 Linda Mays / D		i	19b. Mailing	Address (Street a.	nd Numbe akew	r or Rural	Route Number Avenu	; City or e B	r Town, State, . Baltim	Zip Co	, Md21224
Baltimore, permit. Page 1 and appartment of Hea mportant: If item ny injury or other		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Speci		ce.	meterv. crema	ition (Name of atory or other place n Cemet	9) 9	ctol			ocation - City		m, State Maryland
Baltir Permit. P Departme Importar any injur	-	21. Signature of Funeral Service Licen		M009:	33 22.	Name and Address	s of Facility	Kac	zorows	ki	Funer	al	Home, PA
	+	23a. Part 1. Enter the disease, or com	nlications that caus	ed the death		01 Dund					lmore,		
Ph_sician/ Medical	i	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each li	ne.	Graf	ic CM					for	1	Approximate Interval Between Onset and Death
Examiner	ē	Sequentially list conditions, if any, leading to immediate	b. ———	s a conseque									
uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C	3 a conseque	rice oij.								
760 sate be executed physician and the burial-transit	edical Ey	resulting in death) Last	Due to (or as	s a conseque	nce of):								
876 tificat ng ph	ĕ ĕ	IF FEMALE:											
Division of Vital Records, P.O. Box 687, Hospital or Attending Physician: The law requires that the death certificate hours after death. Funeral Director: After this certificate has been signed by the attending patelly filled in by the funeral director, page 2 should be detached for use as the funeral director.	~ I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3	Ectopic pregnancy Other (specify)	1				23d. Date of o		/ ray Year
P.O.	S F	Part II. Other significant conditions of		but not resul	ting in the un	derlying cause give	en in Part I.		23e. Did to	bacco u	use contribute	to the	cause of death?
ords, P.(Aerhe	Sund						1 □ Y	es 2	№ 10 3 🗆	Proba	bly 4 🗌 Unknown
e law recharge by the bas be	Completed								24a. Was a		24b. Were a	utops	y findings available oletion of cause of
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Vital Re yssician: The	e e	25. Was case referred to medical examiner?	Hospital:				ce of Deatl	h (Check d	only one)	+, +-			
Physical disconnection	2	1 Yes 2 X No	1 ☐ Inpa	itient 2 🗆 E	R/Outpatient 8b. Time of		4 L Nu		ne 5 🛭 Reside	-		ecify)	
Division of Vital Records, P.O. all or Attending Physician: The law requires that the safter death. In Director, After this certificate has been signed by the funeral director, page 2 should be detact.	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, D	ay, Year)	injury	28c. Injury work?	at ′es 2 □ :	- 1	3d. Describe ho	ow injur	y occurred		
Division of the Hospital or Attending Phours after death. The Funeral Director: After the pletely filled in by the funeral control of the		4 Homicide determined	28e. Place of In	ijury - At hom tc. (Specify)	e, farm, stree	t, factory, office		2	8f. Location (St City or Towr			ural R	oute Number,
To the Hospi within 24 hou To the Funer completely fill	Med	only one) 3 L Certifying Nur	ner: On the basis of	examination a	and/or investig	ation, in my opinion	, death occ	curred at the	ne time, date an	d place	, and due to the	cause	e(s) and manner stated.
To t vitt To to com	2	29b. Signature and title opcortifier	51	n		29c. License	number 33	447	_	- 1	te signed (Mor		y, Year)
20		30. Name and address of person who of Dr. Kenneth H	ompleted cause of Willia	death (Item 2 ${ m ms}$, ${ m N}$	3a) (Type, Prii 1 • D • 2	2801 Fos	ster	Ave	nue Ba	alt	imore	, Mc	1.21224
State		1. Date filed (Month, Day, Year)	32. Regist	rar's Signatur	re								
Registrar	11	OCT 2 5 2011	Lenur	B. 10	arkal								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per verb.,920,10/2//2011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Joseph Losinski. Jr. OCTOBER 18 2011 4:13 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 4, 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days New Jersev 141-42-5879 58 **Director** Usual Residence of Decedent 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 x No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Beech Leaf Court 21286 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. OSINSKI, JOHR Black. White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.
is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Losinski, Sr. Joseph Edna Szczepanowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lypartment of Health at Important: If item 27 is any injury or other trainsonce. 53 Barbara Avenue, Spotswood, NJ 08884 Gary Losinski-brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Serv. Corp. 10/21/11 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami inding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Yes been signed by the should be detached 1 L Yes 2 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law this certificate has ral director, page 2 autopsy perform death? performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2**025**No 1 🗌 Yes Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 12 Natural 5 Pending work? hin 24 hours after death.

the Funeral Director: A

mpleted filled in by the ft 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2

To the F

complet To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10-19-2011 30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) Baltimora Kelly 0 norles 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LOVETINSKY FRANCIS ANTHONY Physician/ ocTÖBER 2⁄2, 2011 3:49 AM Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, 4c. County of Death BALTIMORE 320 IDA AVENUE 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Days Hours (Month, Day, Year) 7-9-1927 84 216-20-1014 **Director** MARYLAND Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10d. Inside City Limits 10c. City. Town or Location Director BALTIMORE **ESSEX** 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 320 IDA AVENUE U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Year or Dates. 1945 – 47 Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ESSKAY MEAT CO. 10 MACHINIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LOVETINSKY MARTHA VAVRA FRANK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EVELYN M. LOVETINSKY/WIFE permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PARKWOOD CEMETERY: 10-26-11 PARKVILLE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 21237 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atheroscle Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Yes 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by, page 2 sl autopsy After this certificate funeral director, page performed 1 🗌 Yes 2 🗌 No Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2-1 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death. e Funeral Director: A eleted filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

124 Mace Ave.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) October 2011 6:30 AM Physician/ Alan Larson Glenn Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Libertytown 11913 South St. 8. Date of Birth
(Month, Day, Year)
Apr. 2, 1951 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 🛛 M 2 🗆 F Colorado 60 **Director** 521-68-4463 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Libertytown Frederick Maryland 10g. Citizen of What Country? 10e, Street and Number U.S.A. Funeral 21762 11913 South St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Deceus Armed Forces? ✓ Yes 2 🔀 No 11. Marital Status Black, White, etc. þ 1 Never Married 2 XMarried 1 Yes 2 XNo Specify. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) oumo mfo. salesman 12 18. Mother's Name (First, Middle, Maiden Surname, Be 17. Father's Name (First, Middle, Last) ပ Velta Ora Wheeler Glenn Galen Larson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Libertytown, MD 21762 11913 South St. 27 Sharon L. Larson/ wife or other item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD All County Cremation 10/25/2011 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service LIbertytown, MD 21762 att m 11802 Liberty Rd. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year Month Day in the past 12 months? Pregnant at time of death Yes 2 No Unknown page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 又Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No 1 Inpatient 2 ER/Outpatient 3 🗌 DOA မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 1 Natural Certificate: work?
1 \[\text{Yes} 2 \[\text{No} \] 5 Pending death. Investigation Accident Director: / 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completed filled Funeral Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title 681 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Day

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34282 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 06304M Physician/ Michael P. McNatt October 2011 6:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2107 Long Corner Road Mount Airy Howard 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday Min. Hours **Director** 216-70-4505 1 🛛 M 2 🗆 F 55 Yrs May 30, 1956 Maryland 28a-f show 10b. County 10c. City, Town or Location death with the Maryland Director Michael Mc Natt 10/24/201 items 23a or 28a-f s ler must be notified Maryland Howard 1 Yes 2 No Mount Airy 10e. Street and Number 10g. Citizen of What Country? Funeral 2107 Long Corner Road 21771 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner þ 1 Never Married 2 Married Yes Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alvin Y. McNatt Sylvia Lytle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Watson, Friend 2107 Long Corner Road Mount Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 10/28/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor ²²MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 roman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between attypest notice at Terrios desotic landiovas cular Diseasa Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? 1 **X**Yes 2 □ No ည 4 Nursing Home X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28h Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practitioner: To the best of my Howle who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

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32. Registrar's Signature

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C. Lutherville, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Imend #23aPer PHY G923 1/06/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 1923 M Month DADEAN MERRITT 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY GENERAL MONTGOMERY HESPITAL OLNEY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 082-36-0676 Min (Month, Day, Year, **Director** 1 □ M 2 🏞 F 1948 New York 122 4 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No. MD Howard Laurel 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be Funeral 9120 Blues Alley Ln. Apt. 20723 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: Black Completed 3 Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Alamona Hotel House Keeper N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James Malone Willie Hodges 19a. Informant's Name/Relationship (Type, Print)
Alan J. Merritt- Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,{ t Apt}\,\,\,\,\,\,514$ 2104 Piney Branch Circle Hanover, MD 21076 20a. Method of Disposition

1 Degrial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date King Memorial Pk. 11/5/2011 Randallstown, MD 1 Do ation 5 Other (Specify) of Funeral Service 22. Name and Address of Facility March F/H 1101 E. Signatu Ave. Baltiomore, MD 21202 . Enter the disease, or complications that caus ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ock, or heart failure. List only one cause or Possible Pulmonary Embolism nediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner ARDIORESPIRATORY Securatistic list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the aftending physician and funeral director, page 2 should be detached or use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Pregnant at time of death Month Day Year 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Sa Yes 2 No 船 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Mainpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Registrar

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Souril Suka

SOUVIK

27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SARKAR

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

18101 PRINCE PHILIP DRIVE, OLNEY

29d. Date signed (Month, Day, Year)

2011

29c. License number

			amend item 5 per State of Maryland		920 10-27-11 artment of Health a tificate of Death		giene Reg. No. 2		
Physici Med			1. Decedent's Name (First, Middle, Last) Julia Mae Mosley			2. Date of Dea	ith	3. Time of Death 1:20 a м	
A STATE OF	Examin		4a. Facility Name (if not institution, give street and number) Gilchrist Hospice	4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore			
	Funeral Director		5. Social Security Number 213-360-7308 Usual Residence of Decedent 5. Sex 1	t birthday) Yrs.	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birt Min. /Month, Day 5/1/3	r Year) 7	9. Birthplace (State or Foreign Country) NY	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director		Town or Local	ore			10d. Inside City Limits 1 ☐ Yes 2 😾 No	
			10e. Street and Number 5614 Whitby Rd		10f. Zip Code 21206		10g. Citizen of V	What Country?	
Baltimore, Maryland 21215-0036			11. Marital Status 1 □ Never Married 2 □ Married 3 □ Wildowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.	lf lf	Vas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, I Yes 2 A No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)		e - American Indian, ik, White, etc. Aru (an Am ey (an	
			(Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	(Give k life. DC	ent's Usual Occupation kind of work done during most of O NOT use retired) Phy. Therapy		16b. Kind of Bu	usiness/Industry	
yland			17. Father's Name (First, Middle, Last) James Russell 18. Mother's Name (First, Middle, Maiden Sumame) Eva Darden						
, Mar			19a. Informant's Name/Relationship (Type, Print) William Mosley/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5614 Whitby Rd, Balt., MD 21206						
imore					sition (Name of natory or other place) Star Cem. 1(Date 0/29/11	20c. Location - Balt.,	City or Town, State	
Balt			21. Signature of Funeral Service Licensee		Name and Address of Facility 126 Belair F		lose F MD 212	.Svs,PA 06-5105	
-	h sician/ Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.	ate Cause (Final Onset and Death or condition					
	If or Attending Physician: The law requires that the death certificate be e after death. Director: After this certificate has been signed by the attending physicial of in by the funeral director, page 2 should be detached for use as the buring the buring the funeral director.	Medical Certificate: To Be Completed by Physician	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence or).						
			Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):						
			d						
P.O. Box 6876			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Ves 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown					23d. Date of delivery Month Day Year	
ls, P.O			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chokuldium dylicity Colins, type 2 diebetes				23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 □ Probably 4 □ Unknown		
Division of Vital Records,			nellits, comme tiency di		autop	24a. Was an autopsy performed? 1 Yes 2 No 124b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No			
ta			25. Was case referred to medical examiner? 26. Place of Death (Check only one)						
of V			27. Manner of Death 28a. Date of injury 28	3 U DOA 4 U Nursing Home 5 U Residence 6 P Other (Specify) 28c. Injury at 28d. Describe how injury occurred					
ion			Natural 5 Pending (Month, Day, Year) Accident Investigation Suicide 6 Could not be	work? M 1 ☐ Yes 2 ☐ No					
Divis			4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
:			29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
			29b. Signature and title of certifier		29c. License number			(Month, Day, Year)	
	384	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON D CHANGE MY 670, N - Change ST Toward MY					0		
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature								,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Victoria J. Moroz 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Heritage Center If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖵 F Sept. 24, 1950 Months Davs Min. 61 MD Director 217-52-7914 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Baltimore Essex MD 1 🗆 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 1224 East Riverside 21221 Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐MNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper vacht Club Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Dec artment of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve ည Ethel G. Sanders John W. Heise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Hux /sister 2600 Holly Beach Road Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bமிal 2 🗆 Cremation 3 🔲 Removal from State cemetery, crematory or other place) Oak Lawn Cemetery 10/29/11 Baltimore MD ation 5 Other (Specify) Signaty ce License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury transit that the death certificate be executed that initiated events Ж resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical Box 68760 the as IF FEMALE: yes, outcome of pregnancy nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ō Year Month Day Pregnant at time of death signed by the at d be detached fo g Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 🗌 Yes 2 🗆 No **Division of Vital** 25. Was case referred to medical B B 26. Place of Death (Check only one) Other: 1 Yes 2 No. မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural
 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature

Registrar

State

31. Date filed (Month, Day, Year)

MO

death (Item 23a) Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# I perphis, 6920, 107 27 7201 F.WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Andrew Moore Sr. 2. Date of Death 3. Time of Deat Physician/ Month Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City Town or Location of Death 4c. County of Death Baltimore 1906 Harlem Ave Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**x** M 2 □ F Months Hours Min **Director** 217-38-5567 69 NC Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore MD NA 10e. Street and Number r items 23a or ner must be n 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 21217 1906 Harlem Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces:

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Black Specify: "natural". Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hamilton Associates Machinist 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ۵ Mary Moore Ernest Leggette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1906 Harlem Ave, Baltimore, Md 21217 Sharon Moore-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 11/1/2011 <u>Garrison Forest</u> 21. Signature of Funeral Service Licensee March F/H West Baltimore, Md 21215 4300 Wabash Ave, 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician prostate metastatic cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Securi fally list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? anemra Division of Vital Records, 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed 2 No Yes 2 No 1 TYes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 - 24-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

0/20/11

Indyeur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Martin-Johnson Dorothy 10 2011 11:15p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death **Examiner** Richey Hospice Joseph 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Days Hours 1 □ M 2 🛣 F Director 87 213-26-1810 NC Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be I Funeral U.S.A. 21223 2840 West Mulberry Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
77 is marked other than "r Baltimore City Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) 2yrs Public School Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۴ Pearl Clark Edgar Latimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2025 Madison Ave, Baltimore, Md 21217 permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Juathawala Harris-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Removal from State cemetery, crematory or other place) 10/31/2011 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last 0 attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a P.O. signed t significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performe certificate 2 🗆 No 1 Yes 25. Was case refered to medical or Attending Physician: director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 🗌 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this the Funeral Director: After thi The Funeral Director: After thi The Funeral filled in by the funeral 28a. Date of injury (Month, Day, Year) Mann of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 V Natural 5 \square Pending Accident Investigation
6 Could not be 1 Yes 2 No Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29d. Date signed (Month, Dal, Year) 29b. Signature and title of certifie State Registrar

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. signed by t Records, certificate After this

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 26 MULLINS **Physician** LEE OCTOBER 0630 WILLIAM 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LOCH RAVEN BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sev 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days 1 M 2 □ F 107-22-7071 87 November 24,1923 Director Tennessee Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h Count 10c. City, Town or Location 28a-f show other traumatic event, the Medical Evandour quest be notified at Md. Baltimore Dundalk 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event. 3412 Loganview Drive 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify: White þ Specify: 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American Standard Plumbing Blast Furnace 10 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rov Eli Mullins Margarette Mullins ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Mullins Daughter 3412 Loganview Drive, Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mill, Md. Garrison Forrest 3, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or c implications that caused the de the bound of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPATHY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. filled in by the f 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D30272 reli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 LOCH RAVEN BOULEVARD BAUTIMONE, MOZRY THOMASS. MILLER, MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Saltimore, Maryland 21215-0036

Division of Vital

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2:15 A^{M} Matthew M. Mack 201₁ October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 529 Brent Road Montgomery Rockville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) Director 154-10-9355 1 😾 M 2 🗆 F 91 Yrs. April 26, 1920 New Jersey Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d, Inside City Limits Director 1 x Yes 2 No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r Funeral 529 Brent Road 20850 United States items (Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1943–1963 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th 4 Commissioned Officer <u> Air Force</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jon Maczka <u>Jennie Cieika</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I and 2 sh of Health a fitem 27 i Marian L. Hull/Domestic Partner 529 Brent Road, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or of ŏ cemetery, crematory or other place)
Arlington National
Cemetery 1 X Burial 2 Cremation 3 Removal from State December 21, 4 ☐ Donation 5 ☐ Other (Specify) 2011 <u> Arlington, Virginia</u> Pumphrey Funeral Home/ 22. Name and Address of Facility Robert A. 21. Signature of Funeral Service Licens 300 West Montgomery Avenue Rockville: Inc Mar M01498 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Colon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Distriction as a monspeciment offi Examir nding physician and use as the burial-tran Due to (or as a consequence of). Physician/Medical death certificate be IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Day Year the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Atrial Fibrillation or Attending Physician: The law page 2 autopsy performed? this certificate has 2 No 1 Yes Ischemic Heart Disease 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 $\overline{\mathbf{X}}$ Residence 6 \square Other (Specify) 1 X Yes 2 🗌 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: / filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 2.

Hospital

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

State

completely

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doulas R. 615 West Montgomery Avenue, Rockville, Maryland 20850

Showly a

Shumaker,

31. Date filed (Month, Day, Year)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day. Year)

October 17, 2011

29c. License number

D27301

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 34290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 October 4:30 P^{M} Nghia Τ. Nguyen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery 1613 Hutchinson Lane Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mir Days Hours Director 586-36-4296 1 🗶 M 2 🗆 F 76 February 12, 1935 Vietnam Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits at 10a. State within 72 hours after death with the Maryland Director or 28a-f sh notified a 1 ☐ Yes 2 🙀 No Maryland Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? ö must be Funeral 23a 1613 Hutchinson Lane 20906 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status "natural", or ite 1 Never Married 2 X Married þ 2 X No Yes 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: 3 Divorced 4 Divorced Completed Asian Year or Dates ntal Hygiene. ed other than "natur: event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner Grocery Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked or jury or other traumatic ew 2 Sach Nguyen Long Bui 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phi T. Nguyen / Son 26 Middlebridge Court, Silver Spring, Maryland 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) October 27. 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Signature of Funer Service Licensee (MINIETTE BAPLIS M01305 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Arteriosclerotic Heart Disease Since 1984 Sequentially list conditions, ne if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate I Yes 2 X No 1 ☐ Yes 2 ☐ No the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Yes 2 🕅 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) . Manner of Death 1 X Natural 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work?
1 Yes 2 No s after death. Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 24 hours a Medical 29a. Certifier 1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and titl 29d, Date signed (Month, Day, Year) 29c. License number D26707 October 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 Buckingham Drive, Silver Spring, Maryland 20901 Tung-Pi Lee, MD State OCT 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 34291 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Nicholson 2011 2:30 P. [™] Manning Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 7207 Bellona Avenue <u>Baltimore</u> Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Hours 002-12-4471 Director 1 □ M 2 **X** F 1921 89 Dec. 19, Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7207 Bellona Avenue 21212 U.S.A. ?7 is marked other than "natural", or items traumatic event, the Medical Examiner mu be filed within 72 hours after death Was Deceus Armed Forces? Ves 2 X No Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Completed by 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Goldsborough Nicholson permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e Kathleen Buracker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Schmidt 6124 Buckingham Manor Dr. (executrix) Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 10-29-11 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery Pikesville, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 212126500 York Road Baltimore, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 X No 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? _1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending iniun 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 2011 2064 nd address of person who completed cause of death (Item 23a) (Type, Print) John Bowie, M.D.1734 York Road Baltimore, Maryland

M DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2011 04:50 AM Marcellene Nace Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Glan Burnie Anne Arundel Baltimore Washington Medical Center 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🏻 F Months Days Hours Dec. 09 1934 Country) 76 Yrs. PA Director 209-28-9434 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Glen Burnie Maryland Anne Arunel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7831 Shellye Road 21060 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 X Married Yes 2 X No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Household Homemaker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Shaffer Minnie Witman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7831 Shellye Road, Glen Burnie, MD 21060 Charles E. Nace, Jr. (spouse) Date 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem Crownsville, Maryland 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer Ser 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the dise Approximate shock, or heart failure. ist only one caus Interval Between Onset and Death Immediate Cause (Final MELLITUS Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Ho
9 Unknown been signed by the a should be detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform after death.

Director: After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) Residence \(6 \text{Pother} \) Other (Specify) Medical Certificate: To 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident 1 Yes 2 No Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type,

State Registrar 31. Date filed (Month, Day, Year)

OCT 2 7 2011

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34293 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 100nth 25^{Day} 2011 8:00 AM Joan Marie Pristas Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Villa Nursing Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 219-30-8242 Director 1 □ M 2**X** F 83 Nov 30 1927 Maryland Usual Residence of Decede show or 28a-f shov notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 711 Academy Road 21228 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
sint. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Deceden 2. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade <u>Administration</u> Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Pristas Louise M. Helber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julian Lapides - ATTORNEY 600 Wynhurst Avenue, Suite 246, Balto, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or other Date 1 ☐ Burial 2 🔀 Cremation_3 ☐ Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) 10-26-2011 Baltimore, Maryland Metro Crematory INC 22. Name and Address of Facility Cremation Society Of Maryland 299 Frederick Road, Baltimore MD 21228 23a. Part 1. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhysicial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached fo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗌 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 힏 1 Tyes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 25, 2011

Registrar

DHMH 17 Rev 06-2011

State

WILKENS

3455

32. Registrar's Signature

BACTIMORE MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMBANAM

31. Date filed (Month, Day, Year)

OCT 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carroll C. Porter PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death asedale 1-timore Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) NOV . 6 . 1918 212-07-7206 Days 1 🔀 M 2 🗆 F Min. Months Hours Country) 92 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location Chase 10a, State 10b. Count the Maryland 10d. Inside City Limits Director MD Baltimore 1 Yes 2 X No or items 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with P.O. Box 61 21027 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. þ 1x Never Married 2 ☐ Married Yes 2 No Yes, Give 1 Yes 2 No Specify: 3 Divorced White Completed Year or Dates Maryland 21215-0 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. Do NOT use retired)
Administratior Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary L. Milburn Clinton Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addr 12729 ss (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eastern Avenue Baltimore MD 21220 Howard T. Porter /nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 10/26/11 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Pregnant at time of death Month Day Year Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page yes 2 No certificate 2 🗌 No 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No. ြု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, pale (in) 25 10 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Frank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OC+ 25 TAMES KichA/ds MAMILS Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** toward General Columbia DUNTY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 15 700272 **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c, City, Town or Location Director HOWARD MO ELLICOTT GIT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA SUNSE 2043 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) UPERVISOR CONSTRUCTION and Mental Hygie is marked other injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ CHARLES JAMES RICHARDS PEGG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: If item 27 DRIVE ELLICOTT GITY MO 21043 MARYANN RICHARDS WIFE SUNSET Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/26/2011 WINFIELD, MD CREM Signature of Funeral Service Licenses 22. Name and Address of Facility JN ZUM BWN EH & MON Co. SYKESUILLE BY ELVERSBURG MY 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Atherosclerotic
Due to (or as a consequence of): CATHIOUSSONA disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Pregnant at time of death 2 \(\text{No}\) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signan 29d. Date signed (Month. Dav. Year)

9. Birthplace (State or Foreign Birthpiac Country) MO

WHITE

Approximate Interval Between Onset and Death

1 Yes

10d. Inside City Limits

1 Yes 2 No

To the Hospital or Attending Physithin 24 hours after death.
To the Funeral Director: After it completed filled in by the funeral State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type,

			Please 1	XME OF Print in State of Marylan	Black In	gdelible Int	Ensure /	All Copies	Are Legible) .	
			For State Registrar	State of Marylan		rtificate of E			Reg. No. 201	1 34296	
Ī	Physicia Medic		1. Decedent's Name (First, Middle, Last)	RICKS				2. Date of Dea Month	Day Vaar	3. Time of Death 1235 PM	
	Examin		4a. Facility Name (if not institution, give st MECCY MEDIC 5. Social Security Number 6. Sex	AL CENTER	ast birthday)	13AUT If Under 1 Year	Location of Death TM012 If Under 24 Hrs.	۶	4c. County of Dea	122 CETY	
	Director		246-38-1434 1 X Usual Residence of Decedent	M 2 □ F 8 2	Yrs.	Months Days	Hours Min.	8/20/1	930	irthplace (State or Foreign ountry) N C	
	iryland i-f shov ied at	Director	10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1 Yes 2 □ No	
	the Ma a or 28¢ be notif		MD N/A 10e. Street and Number	ва.	ltimo	10f. Zip Code			10g. Citizen of What C		
	th with ms 23 must	Funeral	1519 Barclay St		Lion	21202		7 No No.	USA		
9036	ırs after dea ural", or iteı I Examiner	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Ra 15. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Ra 15. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Ra 17. Specify Yes or Nolf Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Ra 19. Specify Yes or Nolf Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Specify Yes or Nolf Yes or Nolf Yes or Nolf Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.)							14. Race - Am Black, Whi Specify: B	White, etc.	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)	cation e completed) College (1-4 or 5+)	(Give I	dent's Usual Occupa kind of work done d O NOT use retired) ator		ing	16b. Kind of Business W R Grace		
and	ntal Hyg ed oth	To Be	17. Father's Name (First, Middle, Last)						Maiden Surname)		
lanyl	should be to and Menta		Charlie Ricks 19a. Informant's Name/Relationship (Type			-	and Number or Run		; City or Town, State, Z		
e, ⊠	and 2 s Health tem 27		Shirley L. John 20a. Method of Disposition			Ll Yolan	1		ore, MD 2		
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2' any injury or other tonce.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren	natory or other place	e)	Date 9/2011	Baltimore		
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee	Who Hand	NC NC	Name and Address	ss of Facility Ma Balti	rch F/more,	H East 1: MD 21202	101 E.	
	h sician/ Medical		23a. Parl 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	tive	er the mode of dying	g, such as cardiac		est,	Approximate Interval Between Onset and Death	
-	Examiner	er	Sequentially list conditions, b	Due to (or as a consequ	geal	Cano	er				
	executed an and rial-transit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequ							
09/			resulting in death) Last	Due to (or as a consequ	ience of):						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 54 hours after dath. The tast been signed by the attending physici or the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnar 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnanc Other (specify)	y		23d. Date of d Month	lelivery - Day Year	
ls, P.O.	requires that the de been signed by the s should be detached	by	Part II. Other significant conditions conf	tributing to death but not rest	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
Division of Vital Records,	The law requate has been bage 2 shou	Completed						24a. Was a autop perfor	rmed2 prior to	autopsy findings available occumpletion of cause of	
<u>ta</u>	ician: sertifica ector, p	Be	25. Was case referred to medical examiner?	ospital:		Lou	ace of Death (Chec		32.10		
of V	g Phys er this eral dir	e: To	27. Manner of Death	1 Inpatient 2	28b. Time of	nt 3 ∐ DOA] 28c. Injury	4 ∐ Nursing He / at		lence 6 Other (Spe	ecify)	
ion	tending death. tor: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury		? Yes 2□No				
Divis	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify))			City or Tow			
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 Medical Examine	ian: To the best of my knowler: On the basis of examination Practioner: To the best of my	and/or invest	tigation, in my opinio	on, death occurred a	t the time, date ar	nd place, and due to the	e cause(s) and manner stated.	
	To t with To tl		29b. Signature and the state of the stiffer			29c. License		4	29d. Date signed (Mon		
	V		30. Name and address of person who con				St Paul	Place	13. 16m	(2011 P.MD 21201	
	Stat Registra		31. Date filed (Month, Day, Year) OCT 2.7 2011	32. Registrar's Stynat	bak.	J 1	- 140	, in a	1501 (1711-01)	111111111111111111111111111111111111111	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner City, Town, or Location of Death 4c. County of Death 9. Birthplace State or Foreign If Under 24 Hrs 8. Date of Birth Age (In vrs. last birthday **Funeral** (Month, Day, 1 X M 2 🗆 F Months Min Country) Director 85 219-10-1350 MD Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified N/A Baltimore 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral I 21215 2449 Shirley Ave. USA and 2 should be filed within 72 hours after death w Health and Mental Hygiene. em 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Ⅸ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Black 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) WestingHouse 12th Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beatrice Dennis Nicholas E. Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Howard Marshall-Nephew 3607 Wabash Ave. Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burlal 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 10/17/2011Crownsville, MD Crowns<u>ville Cemt.</u> 21. Signature of Funeral Service Licenses 22. Name and Address of Facility nd Address of Facility March F/H Baltimore, MD 21202 1101 E. North 23a. Part 1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final ns t and Deat Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially (let conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Day Pregnant at time of death Month i signed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 si autopsy perform 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 ည ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 🛛 Inpatient 2 🗆 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending 1 Tes Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signatur

ess of person who con AL-TAUB

31. Date filed (Month, Day, Year)

OCT 2

00565

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rizzoni 24 Eitel Manlio October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Hospice-Casey House Rockville 8. Date of Birth (Month, Dav. If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **X**) M 2 □ F Months Days Min 094-30-7282 Director 86 1925 January 16, Jsual Residence of Decedent or 28a-f show 10a. State 10h County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director be notified Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20817 United States 9011 Honeybee Lane 12. Was Decedent Ever in U.S. Was Deced Armed Forces? Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ori þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Telecommunications Consultant and Engineer Elementary/Seconday (0-12) College (1-4 or 5+) the Telecommunications Page 1 and 2 should be filed wit ment of Health and Mental Hygier ant: If item 27 is marked other i traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Caterina Scandale Enrico Rizzoni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9011 Honeybee Lane, Bethesda, Maryland 20817 Renee S. Rizzoni / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl cometery crematory or other place) Montgomery Crematory October 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Crematorium, Inc. 2011 21. Signature of Funeral Service Livensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. tohn Hills M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Non-Hod kins Lymphoma Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P,O, Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant ☐ Ectopic pregna☐ Other (specify) 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 should be detached Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an autopsy page certificate ☐ Yes 2X No Division of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at injury work? 1 Yes 2 No X Natural 5 Pending Accident Investigation M the 3 🛘 Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined City or Town, State) 24 hours a Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one

7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) Hospice 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) October 24, 2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Geoffrey Coleman, M.D. **ORIGINAL**

201 1

3:30

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 X No

Italy

Black, White, etc.

White

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Registrar DHMH 17 Rev 7/2009

State

29b. Signatur

31. Date filed (Monti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

gnant hths?	3c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of	al death 3 🔲 Ectopi	c pregnancy		23d. Date of delivery Month Day Year
°	g 🗌 Unknown				
nt conditions cor	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.		co use contribute to the cause of death?
				24a. Was an autopsy performed 1 🗆 Yes 2 🔽	
o medical			26. Place of Death (Che	ck only one)	
lo F	lospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing F	lome 5 ☐ Residence	e 6 🔽 Other (Specify) HOSPICE
Pending Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
Could not be determined	28e. Place of Injury - At he building, etc. (Specif		ory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
Certifying Physi Medical Examin	cian: To the best of my know er: On the basis of examination	rledge, death occurred on and/or investigation,	at the time, date and place, in my opinion, death occurred	and due to the cause(at the time, date and pl	s) and manner as stated. ace, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 X No

Delaware

2011

USA

Medical

14. Race - American Indian.

White

Black, White, etc.

Baltimore County

4c. County of Death

5:15 A M

State Registrar

Jaspital v.
4 hours after dea...
-ral Director: After

within 24 hours a

To the Funeral C

completely filled

Medical

JACKIE JONES, CRNP 31. Date filed (Month, Day, Year,

27

5 Pending

Investigation 6 Could not be

1 X Natural

3 Suicide

29a. Certifier (Check

29b. Signature and

4 - Homicide

Accident

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

f person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month October 2011 08:07 PM Russell William Rogers 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Glen Burnie 210 Bertram Circle Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 214-04-7799 1 🛛 M 2 ☐ F Yrs 61 Jan. 03 1950 MD Usual Residence of Decede 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🖾 No Maryland Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? USA 21060 210 Bertram Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 X Married White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Welder 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Lena Loughry Russell Richard Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 210 Bertram Circle, Glen Burnie, MD 21060 (spouse) Sharon L. Rogers Date 25 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State Baltimore, Maryland 2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 311 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician/ Medical Examiner

and

Department of Heath and Important: If item 27 is n any injury or other traum:

Physician/

Medical

Examiner

Funeral

Director

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notified

items 23a or ner must be n ö

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should be file h and Mental H is marked o

other t

within 72 hours after

Baltimore, Maryland 21215-0036

Medical Examiner

the

traumatic

Director

Funeral

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Completed

Be

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10a State

28a-f shov

signed by 1 d be detach page 2 s To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director, 1

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardual /m Due to (or as a consequence of):	farction	Onset and Death
Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. — Due to or as a consequence of r	2	
edical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of): d.		
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date Mont	of delivery h Day Year
	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?
Completed by			autopsy pri	ere autopsy findings available for to completion of cause of ath?
Be	25. Was case referred to medical examiner?	26. Place of Death (Check o	only one)	
0	1 Yes 2 100	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 Desidence 6 Other	(Specify)
Certificate:	27. Manner of Death 1 Netural 5 Pending 2 Accident Investigatio	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred	
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Street and Number City or Town, State)	or Rural Route Number,
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29d. Date signed (Month, Day, Year)

TCHIR HOY PASADENA, MD 21122

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Dav. Year

11-07947 Diana Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Diana Smith Diana	olace (State or atry) Maryland od. Inside City Limits of Pes 2 No y? tes in Indian, Black, ite dustry al tip Code) 236 own, State Maryland aryland
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The state of Death (Check only one) 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 2 N	icene
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3 Suicide 6 Could not be determined (Specify) 3 Suicide 4 Homicide 4 Homicide 4 Homicide 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 29c. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 29c. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 29c. Certifier (Check only one) 29d. Certifier (Check	41.0
Here is a second of the control of t	cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) October 23, 2011	
30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	i, Day, i eai /
State State Registrar State Registrar	, vay, rear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34302 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Schneider 12:20 PM JOYCE October 701 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Randallstown Baltimore Season Hospice at Northwest If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Age (In vrs. last birthday 8 Date of Birth Date of birst (Month, Day, Year)
Tan 27 1947 **Funeral Director** 269-46-8767 1 □ M 2 🛣 F 64 Ohio Usual Residence of Decedent 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 106 Shady Nook Avenue 21228 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ori 1 Never Married 2 X Married by Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural". Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Craftsperson 4 years Textiles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental 1 ant: If item 27 is marked o ည Arthur E. Michaels Florence K. Winner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Schneider - HUSBAND 106 Shady Nook Avenue, Baltimore, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of P
Important: If ite 1 ☐ Burlal 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC 10-31-2011 Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final Onset and Death Condiovascular Disease Physician/ Atherosclerotic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Hospita 2 No Other: ျှ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending P 24 hours after death. Funeral Director: After the 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the l within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

WSICA HOWM 29c. License number DOUS 7-46 5 29d. Date signed (Month, Day, Year) 10/27/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bullingre MD 21209. 5203 2835 Smin N. S Rayapakse, M.D 32. Registrar's Signature State OCT 27 2011 Registrar

68760

Box

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34303 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1169 Physician/ OUIS 705A 2011 10 24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Rosedale Baltimore Sa FRANKLIN HOSPITa If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Month, Day Year) 1 M 2 - F 85 MARYLAND Director 219 18 1131 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits with the Maryland notified at Director 28a-f MD BALTIMORE 1 ☐ Yes 2 🔀 No WHITE MARSH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 5934 EBENEZER ROAD 21162 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Black, White, etc. 1 Ves 2 No If Yes, Give WWII Year or Dates. ŏ þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: "natural" Completed 3 Widowed 4 Divorced WHITE event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N PETRO ENGINEERING CEO Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LEOPOLD SCHLOGEL CATHERINE ROEMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE MAURENE SCHLOGEL/WIFE 5934 EBENEZER RD WHITE MARSH, MD 21162 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 듇 = 5 1 Burial 2 XCremation 3 Removal from State metery, crematory or other place
METRO CREMATORY Department o Important: If any injury or 10/31/11 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME CHESACO AVE BALTIMORE, MD 21237 1211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on, ach line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury that initiated events Exami burial-trar resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 \square No 1 Inpatient 2 ER/Outpatient 3 IDOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Watural injury 5 Pending s after death. 1 Yes 2 No the f Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a Medical 1 Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29c. Licens Name and address of person who completed cause of death (Item 23a) (Type, Pric 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 201^{Year} 12:24P M 21 David Soko1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Sex 1 X M 2 □ F Months Days Hours Min Oct. 22, New York 577-40-4988 1922 Director 88 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 🌠 Yes 2 🗌 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 1606 Martha Terrace United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 \(\sum \) No \(1940 \) Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 nan "natural", Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: 1947 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Insurance Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 Ruchel Berezowski Eli Sokol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 1606 Martha Terrace, Rockville, Maryland Hilda M. Sokol/Wife 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 1 cemetery, crematory or other place)
Arlington National
Cemetery permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Arlington, Virginia Pumphrey Funeral Home/ M00803 22. Name and Address of Facility Rockville, Inc. Rockville, Maryl Robert A. 21. Signa of Funeral Service Licenses Inc. 30 Maryland 300 W. Montgomery Avenue nd 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line hours Immediate Cause (Final Ph sician/ Cerebral Herniation disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cerebrovascular Infarction 5 days Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Examir 5 days Carotid Stenosis/Thrombosis and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 10 years 68760 Peripheral Vascular Disease as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 Hinknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9. þ 1 Yes 2 No 3 Probably 4X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? certificate 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🔀 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify this (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After 1 X Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) City or Town, State)

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifie

29b. Signature and title of certifie

Michael P.

31. Date filed (Month, Day, Year)

holice

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Siegenthaler, M.D.

149/Q1 i4D

1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Carlinging Number Exaction on To the basis of my knowledge of all popular at the time. Date and place, and the time to the cause (s) and manner as stated.

D0068474

8600 Old Georgetown Road, Bethesda, MD

29d. Date signed (Month. Day, Year)

Odober 21,2011

20814

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jav. d Ctober 24 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Months 1 🔀 M 2 🗆 F 51 217-80-5465 **Director** May 20,1960 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show ems 23a or 28a-f sh r must be notified a 1 ☐ Yes 2 ☑ No Baltimore Dundalk Director Mdwith the 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 1727 Randolph Ave. 21222 USA Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No 11. Marital Status Black, White, etc. "natural", or iten edical Examiner r Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 2**½** No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify þ If Yes. Give Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry er than "natur the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) س withii ا کت ت ا کت is marked other than "r r traumatic even" College (1-4 or 5+) Elementary/Secondary (0-12) Autobody Repair Automotive 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lesley D. Stout Mary P. Davis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 1727 Randolph Ave. Dundalk, Md. 21222 Dorothy Stout Health tem 27 i item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any Injury or ot October 1 Removal from State Middle River, Maryland Holly Hill Memorial 4 ☐ Donation 5 ☐ Other (Specify) 29, 2011 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 I. Enter the disease of complications that caused the complications that caused the complications that caused the complications that caused the complex complex to the complex cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 \square No 9 Unknown Division of Vital Records, P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown ate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient ည this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I Director: After the 1 Natural Injury 5 Pending investigation 1 Yes 2 No Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office bullding, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie tober 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Dame ava

DHMH 17 Rev 1/2001 11595

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

11-07977

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oseph Roland S		1- For State	State o	f Maryla	and / D	epartm Certific				Menta	al Hy		eg. No. 2	0 1	1 3430
Physicia ledical Exami	an/	Registrar 1. Decedent's Name (First, I Joseph		Roland		Sei	ubott		Jr		i i	Date of Deat Month October 2	th Day Year		3. Time of Death 1645 hrs
maioai Exa		4a. Facility Name (if not inst						b. City, To	wn, or L	ocation of		October 2	4c. County of		ity .
Funeral Director		5. Social Security Number 214–06–2363	6. Sex	1 2_F	7. Age (Ir	yrs. last bi	rthday) Yrs.	If Under Months	1 Year	If Under Hours	24Hrs. Min.		th(MM/DD/YYYY) 19,1984	9. Birth	place (State or
nd show any	7	Usual Residence of Decede 10a. State 10b. Cou		ore	100	c. City, Tow	n or Locatio		ldle	Rive	r			- 1	10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 9 Sproul	Court					10f. Zip (1220		10	0g. Citizen of Wha	at Count	ry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4	Married Divorced If	12. Was Dec Armed Fo 1 Yes Yes, Give Yes	orces?		If Ye	Deceder es, specify	Cuban,	Mexican, I	n? (Spe Puerto R	cify Yes or No ican, etc.)	- 14. Race - White,		an Indian, Black,
336 thin 72 hours a ne. than "natura (edical Examir	Completed by	15. Decedent's Education Elementary/Secondary (0 12 years	Specify only	College (1	1-4 or 5+)	ted) 16a	. Decedent during mo	st of work		DO NOT u			16b. Kind of Bus		oration
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Mi Joseph R. S 19a. Informant's Name/Rela	eubot			110	9b Mailing	Address		В	arba	ra Kar	Maiden Surname) Www.att ber, City or Town	State	Zio Code)
MD 2 nd 2 shoul alth and N m 27 is n	٩	Rebecca Seuk			Wife		-	roul	Cour	ct, M	iddl		r, Md. 2	1220)
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		1 Burial 2 Crem 4 Donation 5 Oth	er Specify:		om State	crema	atory or oth LEW C	er place) remat	ory	(0ctc 25,	ber 2011	Baltim	ore,	Maryland
Physician Physician		21. Signature of Funeral Se	e, or complic	ations that o	well caused the	death (bo	7	110 5	വി	ers P	oint	Road.	Dundalk Dundalk est, shock, or hea	-Md	21222 Approximate Interval
/Medical Examiner		failure. List only one c Immediate Cause (Final dis or condition resulting in dea	ease a. In	traoral G te to (or as a							-				Between Onset and Death
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initial	use	ue to (or as a	a conseque	ence of):			46						
be executed ician and urial - transit	I Exami	events resulting in death) L		ue to (or as a	a conseque	ence of):									
60, ate be executed hysician and e burial - transi	Medical	UNPENDED IF FEMALE:		AMENDED 23c. If yes,	outcome o	of pregnanc	у						23d. Date of o	delivery	
Box 68760, e death certificate be execut the attending physician and ed for use as the burial - trai	Physician/M	23b. Was decedent pregnan past 12 months? 1 Yes 2 No 9	in the	1 Live to 4 Pregr	nant at time	e of death	- H	aldeath ner (Spec	3 [fy)	Ectopic	pregnan	су	Month	Da	ay Year
ires that the signed by the detache	ð	Part II. Other significant co	enditions o	ontributing t	o death bu	t not resulti	ng in the u	nderlying	cause giv	ven in Part	t I.		s 2 No 3	Proba	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Completed											1 Yes	osy pi rmed? de	/ere auto nor to co eath? Yes	opsy findings available ompletion of cause of
Vital Rec hysician: The this certificate I	o Be	25. Was case referred to me examiner? 1 ✓ Yes 2 No		spital: 1	Inpatient	2 ER/	Outpatient		10	of Death (Cother			Residence 6 ✓	Other:	Scene
Division of ' tal or Attending Ph Is after death. In Director: After t led in by the funeral	Certification: T	27. Manner of Death 1 Natural 5 Accident	Pending Investigation	Oct 23,); ^{Day,Year)} 2011	FO	. Time of Ir UND: 30 hrs	u.	1 Y	at Work? es 2 ✓ I	No S	ubject sho			al Route Number, City
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i		3 ✓ Suicide 6 4 Homicide 29a. Certifier ← Continuity	Could not be determined	(Specify)	Single	Family	Home				9	or Town, S Sproul Cou	State) rt, Middle River, se(s) and manner	MD	
To the Hos within 24 h To the Fun completely	Medical	2 Medica	Examiner: 0	n; To the be On the basis and manner s	of examina	ation and/o	investigat	ion, in my	opinion,	death occ	urred at	the time, date	and place, and du	ue to the	cause(s)
	2	29b. Signature and title of o	m	>_				290.	O.C.N				October 24	·	, var, . ear/
6V		30. Name and address of polyage. Laron Locke MD.	Assista	nt Medica	al Exam	iner 90		ltimore	Street	, Baltim	ore, M	D 21223			
S	tate	31. Date filed (Month, Day,	Par)	32. R	egistrar's S	Signature	bout	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Catherine Pauline Silk Oct 22, 2011 18:30_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Worcester Berlin Atlantic General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) Jan 15, 1926 214-22-8858 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits with the Maryland Examiner must be notified at 10c. City. Town or Location Director Ocean Pines MD Worcester 1 ☐ Yes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1138 Ocean Parkway 21811 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural". Completed 3 ☐ Widowed 4 ☐ Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry should be filed within 72 Is and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Bank Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Alt Marie Shanahan ge 1 and 2 should b t of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s. Department of Health a Important: If item 27 is any injury or and 1138 Ocean Parkway Ocean Pines, MD 21811 Debbie Doyle daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crematory, LLC 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Oct 26, 2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part . Inter the Vise . e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Approximate Interval Between Onse) and Death 250 Immediate Cause (Final disease or condition Valle Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 DOB 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Day Month Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?-Yes 2 X No cate has page 2 s 1 🗌 Yes 2 🗆 No 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner? Other: 2 X No မ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 🗆 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 2 Accident 5 Pending 2 🗆 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year, dress of person who completed cause of death (Item 23a) (Type, Print) 017 0 31. Date filed (Month, Day, Year)

OCT 2 7 2011 32. Registrar's Signatur Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:45 P M OCTOBER 24, 2011 KATE STOLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MANOR CARE RUXTON TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/20/1907 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛣 F 218-48-1162 104 MD Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinant must be collined at 1 ☐ Yes 2X No Director MD BALTIMORE LUTHERVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11704 WOODLAND DRIVE 21093 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 □ Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Com 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev FOX CHARLES LEAN FANNIE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHUCK WEINER/GRANDSON 2809 GRASTY WOODS LANE, BALTIMORE, MD 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10/26/2011 4 ☐ Donation 5 ☐ Other (Specify) ANSHE NEISEN CEM. BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition brurastular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ly pertens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) signed by the P.O. 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 2 No 1 □Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 201No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation n 24 hours after death.

he Funeral Director: Af
pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

∫ √ State

State 31. Date filed (Month, Day, Year)
Registrar

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05/ex

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Drive,

32. Reperar's Signature

JOWSUN,

DIVISION OF VITAL RECORDS, P.O. DOX 00/00
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after charb.
To the Funeral Director: After this certificate has been signed by the attending physician and

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		For State Registrar		Siai	e oi ivi	iaryiani	•	tificat			and iv	/lental Hy		0	0 1	21.	310
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Physicia Medio		VIVIAN			SHA	APIRO						OCTOBE	R 24	ي او و ع	Year) 1 1	10:25	P M
Examin	er	4a. Facility Name (if not institution, give street and number) EMERITUS OF WESTMINSTER							Town, or ESTMI				40	4c. County of Death CARROLL			
Funeral		5. Social Security N	umber	6. Sex		ge (In yrs. Ia	ast birthday)	If Under		If Under Hours		8. Date of Birt			9. Birtl	hplace (State or I	Foreign
Director		217-07-4 Usual Residence		1 □ M 2 X	F	95	Yrs.	WOILIIS	Bayo	110010		02/18/		,	000	MD	
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should be filed within 7; and Mental Hygiene. is marked other than aumatic event, the Me	2	GEORGE			GF	REENB	ERG			ROS		o (i ii o (i iii da o)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ISHER	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		19a. Informant's Na			ידי סטויוי	ZV	19b. Mailin		CHARL	nd Numb	ENTE	Route Number R H FL, B	r, City o	r Town, S	state, Zip	Code)	1
permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disp	position			20b. Pl	lace of Disportemetery, crem	sition (Nar	ne of			Date				Town, State	L
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Attend r death ctor: A	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6 Could determ	not be	Place of Inju	ury - At hor	me, farm, stre	M eet, factor		Yes 2	-	28f. Location (S	Street ar	nd Numbe	er or Rur	ral Route Numbe	r,
oital or afte aral Dire						c. (Specify)						City or Tow					
the Hosp nin 24 ho the Fune	Medical	(Check 2 only one) 3	Medical E	xaminer: On the	e basis of e	examination	and/or invest	igation, in	my opinior	n, death o	ccurred at	nd due to the ca t the time, date a ace, and due to t	nd place	e, and du	e to the c	cause(s) and manr	ner st <i>a</i> ted.
7 With		29b. Signature and	title of certifier	11		ham	- AN	290	: License	number	40					2011	
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Stat	10	31. Date filed (Mont	h, Day, Year)			ar's Signat	ure			пето	IILS	Medic Westm				D 2115	7
Registra	ar		OCT 27	2011	Denn	4	1	arka	/								

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lillian October Μ. Schwarz 2011 01:33 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 5. Social Security Numbe 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min (Month, Day, Year) 213-12-6863 **Director** 1 □ M 2 🏻 F 91 Yrs. MD Sept. 28 1920 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 X No Pasadena 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be i Funeral 755 215th Street 21122 USA permit. Page 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items. any injury or other traumatic event, the Medical Examiner musonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Westinghouse Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Otto Elmer Romm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Metzger (daughter) 215th Street, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Maryland Veterans Cem Crownsville, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Lios se 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ few minutes Cardiac Arrythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury Insulin Dependent Diabetes attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director. After this certificate has been signed by the attending physicis Chronic renal Insufficiency Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year ed by the a P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ s been signer Division of Vital Records, Hypothyroidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Peripheral arterial disease 24a. Was an cate has performed Anemia of chr. disease, dyslipidemia Yes 2 X No 2 No 1 Yes sompletely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 X ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Rhandelin Rita Khandelwal, MD D29873 10/24/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Khandelwal, MD,313 Hospital Drive, Glen Burnie, MD 21061 31. Date filed (Month, Pay, Year)

OCT 2 7 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Taurone 3:20 PM Anna 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Battimore St. Agnes HOSPITAI Social Securit Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral (Month, Day, Ye 1 □ M 2 🗓 F Days Hours Min. 127-20-5002 Pennsylvania **Director** 1918 March Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore N/AMD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 Funeral 1233 South Grantley Street USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: 3 ☒ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Sokol John Koprla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1233 South Grantley Street, Baltimore MD 21229 Mike Taurone-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Pompton Reformed Cem. Oct. 29,2011 Pompton, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Seizure disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hours rdiogenic Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 signed by the attending pd be detached for use as: IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ► No Day 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director, After this certific **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending 1 Matural ☐ Accident Investigation completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 46505 October 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) am 900 Caton Avenue. osuph Twanmoh

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25^{Day} Physician/ Month 10 2011 Kailashben B. Vaidya 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 201 Duke Of York Lane Apt #101 Cockeysville Baltimore 8. Date of Birth (Month, Day, Year) 1 1922 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Country) India Director 217-43-9491 Usual Residence of Decedent or 28a-f show 10b. County 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Cockeysville 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 201 Duke Of York Lane Apt #101 21030 India 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify: Asian 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Parvatishankar H. Shukla Shantaben Shukla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 201 Duke Of York Lane Apt #101, Cockeysville Bhaskerrao Vaidva - HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC | 10-29-2011 | Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MacNabb Funeral Home P.A. 301 Frederick Road, Baltimore MD 21228 23a. Part 1. Enter the disease, or complications that caused the darth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO PULMONARY FAILURE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events MOIZHOTABATH Due to (or as a consequence of): resulting in death) Last Physician/Medical FAILURE CHRONIC REMAL IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\sum_{\text{Nursing Home}}\) Nursing Home 5 \(\sum_{\text{Residence}}\) Residence 6 \(\sum_{\text{Other}}\) Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge double or the cause of my knowledge double or the c At the time, date and place, and due to the 29c. License number 0062704 26, 2011

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

3290 N. Ridge Row, Switcion

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 2 7 2011

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32. Registrar's Signature

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	•	For State of IV State Registrar	aryland / I	Department of F Certificate of		, ,	leg. No. 201	1 34315	
Physici /Medio		1. Decedent's Name (First, Middle, Last) Robert Arthur Will	iams			2. Date of Dea Month	24 201	3. Time of Death 3.21 P M	
Funeral Director	er	4a. Facility Name (If not institution, give street and number 5. Social Security Number 213-76-2591 Usual Residence of Decedent 10a. State 10b. County		Yrs. ROSEL If Under 1 Year Months Days	r Location of Death C E If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan10	9. Bir	th C thplace (State or Foreign buntry) MD	
he Maryla 28a-f shor	Director	MD Baltimore	,	Middle Riv	er		10 02	1 □Yes 2 □No	
s 23a or 2		10e. Street and Number 53 Longeron Drive	5	10f. Zip Code	21220		USA		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarual court is must be must also	d by Funeral	11. Marital Status ★□ Never Married 2□ Married 3□ Widowed 4□ Divorced 12. Was Deceden Armed Forces 11. Yes, Give Year or Dates	?	13. Was Decedent of H If Yes, specify Cub		ecity tes or No- Rican, etc.)			
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours at partment of Health and Mental Hygiene. portant: if item 27 is marked other than "natural", or y injury or other traumatic event, the Medical Evanit. &ce.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or	5+)	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired elder	oation during most of work d)	ing	16b. Kind of Business Fence Ma		
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should nd Mer marke imatic	၉	Darton Williams 19a. Informant's Name/Relationship (Type. Print)	191	b. Mailing Address (Street		Browne I ral Route Numbe		Zip Code)	
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imore Pages 1.8 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	_ cemete	of Disposition (Name of ery, crematory or other plac iew Cremat	ce)	Date 28/11	20c. Location - City of Baltimor		
Balt permit. Departi Importi any inj		21. Signature of Funeral Service Licensee	w	22. Name and Addre	3		e Ave. Ba me of Ess		
icate be executed by Medical maximum physician and physician and the burial-transit by t	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Hijury that initialted events c.	s a consequence	e of):	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
O. Box 6 ne death certif the attending hed for use as	Physician/Medical		2 Fetal deat at time of death	th 3 Ectopic pregnant 5 Other (specify)	gy		23d. Date of d Month	elivery Day Year	
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al Record 1: The law requir ficate has been si r, page 2 should	Completed		_						
Yit ysiciai ysiciai is certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital:	tient 2 □ ER/O	Outpatient 3 DOA Oth	26. Place of Dea			necify)	
Division of Vital Records, at or Attending Physician: The law requires the refer death. Director: After this certificate has been signed in by the funeral director, page 2 should be or a first the funeral director.	Certification: T	1							
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the basis and manner: and manner:	of examination a						
To the Hos within 24 h To the Fun	Mec	29b. Signature and title of certifier Solve the signature and title of certifier When the signature and title of certifier 30. Name and address of person who completed cause of the signature		29c. Licen.	se number		29d. Date signed (Mo	nth, Day, Year)	
		30. Name and address of person who completed cause of	death (Item 23a)) (Type, Print)	3				
y √ Sta	ite	31. Date filed (Month, Day, Year) 32. Regis	1 9000 ftrar's Signature	tranklin sq	yore Dri	ve Balt	imore, Mi	21237	
Registr		OCT 27 2011 Center	v 3.	gare					

		1 - State Registrar Cer	tificate of Death	Reg.	No.
Physic	:ian/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
Med	dical	10BIN WILKING			2011 855 AM
Exam	iiner	6005 Framingham Rd	4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign
Directo	or	220-84-8801 1 M 2 1 46 Yrs.	Months Days Hours Min.	oct 24,1	965 Country) MD
and show at	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits
Maryla Ba-f s tified	lect.	Baltimore Baltim	ore		1 ☐ Yes 2 😾 No
a or 2 be no		10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
th with ms 23 must	Funeral Director	6005 Framingham Rd	21206		USA
or ite	by Fu		Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.
Z I Z I D-UUSO within 72 hours after gjene. er than "natural", o , the Medical Exam	ed	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	☐ Yes 2 🛣 No Specify:		Specify: Black
13-C	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give I	lent's Usual Occupation kind of work done during most of wor	king 16	b. Kind of Business/Industry
ithin ithe M	S	Elementary/Secondary (0-12) College (1-4 or 5+) Iffe. Do 10th N/A Cas	O NOT use retired) Shier		pin Cycle aundromat
filed v filed v all Hyg fothe vent,	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
yiand Id be filed Mental Hy arked oth	욘	MODEL MILLOI	Earlen	e Eldrid	ge
DESIGNATION OF INTERPLIANT OF LACE 13-00-50 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Earlene Neals/Mother 19b. Mailir 6005	ng Address (Street and Number or Ru Framingham Rd	ral Route Number, Cit	y or Town, State, Zip Code)
and 2 Healti tem 2		20a. Method of Disposition 20b. Place of Dispo			c. Location - City or Town, State
Dalumore, bermit. Page 1 and Department of Her mportant: If item any injury or othe			natory or other place)		odlawn, MD
Daltill Dermit. F Departm Importal any inju	<u>.</u>		. Name and Address of Facility	erly D	Cromartie F/s
	5	2	700 Edmondson	Ave. Bal	to., MD 21223
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	,		Approximate Interval Between
Physician Medica	_		Adeno cano	190m	Onset and Death
Examine	_	Due to (or as a consequence of):			
_ #	iner	b. Sequentially list conditions, if any leading to immediate cause. Enter Underlying			
physician and the burial-transit	Medical Examiner	C			
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ath certifica attending platfor use as t			Ectopic pregnancy		23d. Date of delivery
box death the atter hed for	Physician/	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)		Month Day Year
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requires t	ed by			1 🗆 Yes	2 No 3 Probably 4 Unknown
e law required has been sig ge 2 should t	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Physician: The law r this certificate has	Con			performed	d? death?
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g Phys er this	e: 10	1 Inpatient 2 ER/Outpatier	it 3 ☐ DOA	ome 5 Residence 28d. Describe how i	e 6 Other (Specify)
anding Feath.	icat	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
or Attendification by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi			popurred at the time, data and place	and due to the equal	(a) and manner as stated
n 24 h	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invest only one) 3 Certifying Nurse Practitioner: To the best of my knowledge,	igation, in my opinion, death occurred	at the time, date and p	lace, and due to the cause(s) and manner stated.
To the vithing to the complete		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		· cayour in	10158/	2 0	cd 24, 2011
A		30. Name and address of person who completed cause of deam (Item 23a) (Type), P	- K'a Bluda	You Run	nip 21061
	ate	OCT O 7 2014			
Regis	rar				

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Virginia Freeman Weil October 2011 6:53 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6822 Delaware Street Montgomery Chevy Chase Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 K F Hours **Director** 389-32-0215 83 Yrs Ohio pril Usual Residence of Decedent with the Maryland 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6822 Delaware Street 20815 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 😾 Married Black, White, etc. Completed by ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 2 🔀 No 1 ☐ Yes 2 X No Specify: White Specify: 3 Divorced 4 Divorced Year or Dates if Health and Mental Hygiene.
item 27 is marked other than "natu
other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) University of Maryland Elementary/Seconday (0-12) College (1-4 or 5+) $5\pm$ <u>Choreographer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Freeman Ella Louise Ludwig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell Taylor Weil/Husband 6822 Delaware Street, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot October 25, cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Hethesda-Chevy Chase 208 Inc. 7557 Wisconsin Avenue do M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 6 months Pancreatic Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and -trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) Yes 2 X No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 2 🗆 No Yes 2 😾 No 1 Tyes To the Funeral Urector After this certifics completed filled in by the funeral director, i Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 👿 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year, October 24, D43083

Registrar

DHMH 17 Rev 7/2009

State

MD 9707 Medical Center Drive, #300, Rockville, Maryland 20850

30. Name and address of person who completed cause or death (Item 23a) (Type, Print)

Sotos,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 13^y 2011 Yinghu Zhang 12:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 933 1 X M 2 🗆 F Months March I. Hours China 215-67-6850 78 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland ms 23a or 28a-f shore must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛣 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17837 Fair Lady Way 20874 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Asian 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Professor Education is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dazhi Zhang Xingrong Wang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Yuanning Zhang /Son 17837 Fair Lady Way, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State October 28 Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral/Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. Insalette Barre M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death metas Physician/ cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 K Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? <u>10</u> 2 X No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Hospital Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, de 29b. Signature and title of certifier 29c. License number **D0068080** 29d. Date signed (Month, Day, Year) Me Oh 10-13-2011.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sireesha Jalli, MD 9901 Medical Center Drive, Roywille, Mayland 20800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 12:08 AM Lois Jeanette Abell October 2011 Medical 4c County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner St. Mary's Mechanicsville 24798 Jones Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Min. 0170571947 Maryland 1 □ M 2 🕱 F Director 64 217-46-9118 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 🗆 Yes 2 🏝 No Mechanicsville Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20659 24798 Jones Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. . Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify White Completed 3 Divorced 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Julia Mae Wilson Charles Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24798 Jones Road Mechanicsville, Maryland 20659 Robert W. Abell / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Dct 19 2011 Alexandria, Virginia Metropolitan 4 ☐ Donation 5 ☐ Other (Specify) Signatur of Funeral Says Local 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, Maryland 20650 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Apset and Death CSYS Immediate Cause (Final METASTATIC CANCER OVARIAN Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the ar q | I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page 2 performed 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1X Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Hospital Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29d Date signed (Month, Day, Year) 29b. Signature and 201 68846 Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 POINT LINKOUT Rd, GEONARD TOWN, MD 2065 ST. MARY'S HOSPITAL

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For 10-24-11 Amend#4a, PerState Off Maryland / Department of Health and Mental Hygiene state 10-21-11 Amend#10e, 196. Per Infrant. PCCC Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09^{Pay} Physician/ 1 Month $2\check{O}^{ar}1$ 10:57 P M Timothy Alexander Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 904 Sero Estate Drive Fort Washington Prince George's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1**¾** M 2 □ F 1270671955 Director Yrs. 55 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumente event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Estates Estate Drive Funeral 904 Sero 20744 United States 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 XMarried ☐ Yes 2X No δ Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wheelerchair Lift Operator Metro Transit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Albert Alexander Dorothy Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Estates</u> Drive, Ft. Washington, MD 20744 Lulu_Hester-Alexander/Wife 904 Sero Baltimore, 20b. Place of Disposition (Name of cemetery, crematory of other place)

t. Mary of Piscataway 10/15/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Clinton, Maryland 4 ☐ Donation _5 ☐ Other (Specify) neral Service Licenses 21. Signature 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Due to for as a sonsequence of: Examin Cause (Disease or linjury that initiated events and trar Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. I s been signed b Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 autopsy performed 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ivan Zama, MD 9200 Basil Court, Suite#200, Largo, MD 20774 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34322 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\overset{\text{Day}}{2}\underline{011}$ Month BETTY В. ADDAMIANO OCT. 11 10:55A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14877 POPLAR HILL ROAD ACCOKEEK CHARLES Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Year) 918 1 - M 2 - F Days Min FEB. 23 Director NEBRASKA 384**-**22**-**5913 93 Yrs Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits VA **FAIRFAX** 1 🗆 Yes 2 😾 No ALEXANDRIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4222 ROBERTSON BLVD 22309 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: WHITE "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I once. SCHOOL TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ JESSE OATMAN BETTERTON MARY WALSH DEAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAOLA ADDAMIANO-CARTS/DAUGHTER 14877 Poplar Hill Rd, Accokeek, Maryland 20607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 \square Burial 2 \cancel{K} Cremation 3 \square Removal from State NATIONAL CREMATORY 10/14/2011 | FALLS CHURCH, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility DEMAINE FUNERAL HOME 520 S. WASHINGTON STREET ALEXANDRIA, VA 22314 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or initially that initiated events Due to (or as a consequence of) Exami burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a. Was an autopsy perform After this certificate Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify 4 Nursing Home 5 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? death. Accident М 1 \square Yes 2 🗌 No Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person

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completed cause of death (Item 23a) (Ivpe, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 12 201^{Yea} SALVINA G BENJAMIN 1:10 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHESTERTOWN NURSING & REHAB CHESTERTOWN KENT . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** . Age (In vrs. last birthdav) 9. Birthplace (State or Foreign IL Country) 1 □ M 2 □XF Months Days Hours 342-14-1636 1272871923 **Director** Yrs 87 Usual Residence of Decedent 10a. State 10b. County the Maryland notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 X Yes 2 No MDKENT CHESTERTOWN ö 10e, Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 200 WALDO DRIVE 21620 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 5 þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 XWidowed 4 ☐ Divorced Specify: WHITE Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than, College (1-4 or 5+) Elementary/Seconday (0-12) 12 BANK TELLER BANKING event, th Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked ot traumatic ever ပ MICHAEL GIARRUSSO CLARA ODDO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a: If item 27 is 1602 MCGINNIS ROAD CHESTERTOWN, MARYLAND 21620 JOHN M. BENJAMIN / SON other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State ō Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) CHESTER CEMETERY 10/18/2011 CHESTERTOWN, MARYLAND 21. Signature of Funeral Service Licensee HOME 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions. if any, loading to initiodate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on. Exami and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 month Month Pregnant at time of death Day Year signed by the a 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 the Funeral Director: After this certificate Inpleted filled in by the funeral director, page 1 🗌 Yes 2 🗀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending (Month, Day, Year) Natural 5 Pending injury Division work?
1 \(\sum \) Yes 2 Accident
3 Suicide
4 Homicide death М 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie 29c. License number 0

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

strar's Signature

Such

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend#1perMD FCHD 10/18/11 Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bulah Viola Bishop-Johnson Physician/ Month Viola Beulah Bishop-Johnson October 2011 14:37 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 01ney Montgomery General Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 228-52-5198 **Director** 70 1 🗆 M 2 🕱 F Sept. 28 1941 Virginia Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be martical any once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Ashton 1 Yes 2 X No |Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20861 United States 17800 Striley Drive Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Ď 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home 12 Activities Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Doane Nannie Paul Edward Crusenberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4165 John Benjamin Dr., New Windsor, MD 21776 Robert E. Bishop / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Burtonsville Union 10/11/11 Burtonsville, MD 4 ☐ Conation 5 ☐ Other (Specify) 21. Signatur of Tunera Service Licensee Name and Address of Facility
Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville, 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Bacterial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine * Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. * Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hodg Rin Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🔀 No 1 Yes __ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Cate of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) and D39197 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 Joseph Garrett Reilly, M.D. 3418 Olandwood Court, #111, Olney, MD 20832 31. Date filed (Mo CTT2 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 2011 2:02P M Genevieve May Bowman 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Goodwill Mennonite Home Grantsville Garrett 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 M 2 XF Hours Month, Day Aug. 25 Maryland 83 Yrs 200-20-4108 1928 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 1 Yes 2X No MD Garrett Swanton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 177 North Glade RD. 21561 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ivory Cecil Rounds Florence May Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Linda</u> J. Green/ Daughter 13458 Bittinger RD., Grantsville, MD 21536 20b. Place of Disposition (Name of General Country Dags) Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/12/11 | Oakland, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Peath disease or condition resulting in death) Due to (or as a co Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury that initiated events equence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Day Month Year

Physician/ Medical Examiner

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1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. if item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Exami

Physician/Medical

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Completed

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Certificate:

Medical

only one) 29b. Signature and title of certifier

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physician a the burialattending p ed by the a signed b certificate has page after death.

Director: After this certification by the funeral director, filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

9 🗌 Unknown	9 ∐ Unknown	
Congesi	contributing to death but not resulting in the underlying cause given in Part	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown
	imer dementiq	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 No.	ursing Home 5 Residence 6 Other (Specify)
. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? M 1 \(\sum Yes 2 \sum \)	28d. Describe how injury occurred
4 Homicide determined	1 280 Diago of Injury At home form street feature office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 \(\superpressure \) Medical Exar	ysician: To the best of my knowledge, death occured at the time, date and miner: On the basis of examination and/or investigation, in my opinion, death or irse Practioner: To the best of my knowledge, death occurred at the time, date	ccurred at the time, date and place, and due to the cause(s) and manner stated.

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Registrar

Year,

30. Name and address of person who completed cause of death (Item 23a) (Type Naeem

within 24 hours a

To the Funeral D

completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 4, 2011 4:40 Sara Celina Blocher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg Village Nursing Home Frostburg If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 🗆 M 2 🕱 F Hours Feb. 17, , 1918 Mary Land 93 Director 216-18-1691 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State must be notified at Director 28a-f 1 K Yes 2 No Garrett Grantsville MD 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21536 206 Grant St. USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【X No If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma Missouri Blocher William Lewis Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26505 21 Nordic Dr., Morgantown, WV f Health item 27 Pat Cleavenger/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Grantsville Cemetery Oct. 8, 2011 Grantsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMERS Physician/ DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter chaerlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ned by the atter detached for u in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; to 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: Other (Specify) Assisted Living 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical to certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

OCT 07

Helly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit Sidhu, MD, 925 Bishop Walsh Rd.,

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number 1)26907

Cumberland, MD

29d. Date signed (Month, Day, Year)

21502

UCTUBER 05, 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #6 Per FH G921 11/02/2011 JH
State of Maryland / Department of Health and Mental Hygiene 2011

		•	For State Registrar	" State of Ma	ıryland /		rtment of F ificate of D		Mental Hy	giene Reg. No.	201		34327
	Physicia		Decedent's Name (First, Middle, La Willie Mae Bo.)						2. Date of De		011 Year		Time of Death
	Medic Examin		4a. Facility Name (if not institution, give Caroline Nursing				4b. City, Town, or Denton	Location of Dea	ath		County of De		
_	Funeral Director		5. Social Security Number 16.5		(In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th	9. B	irthplace	(State or Foreign
		tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation						nside City Limits
	the Mary or 28a-f e notifie	Director	MD Talbot 10e. Street and Number		Easto	n	10f. Zip Code			10g. Cit	izen of What (I ☐ Yes 🎢 ☐ No
	ath with ems 23a r must b	Funeral	8817 Roundhouse	Cir.	ver in U.S.	13. W	21601	spanic Origin? (\$	Specify Yes or No-		USA 14. Race - An	nerican în	dian.
2-003p	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.	No	If	Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)		Black, Wh		
-61717	ithin 72 hou ene. r than "nat he Medica	Completed	15. Decedent's I (Specify only highest gas Elementary/Seconday (0-12) 1 2		-)	(Give k	ent's Usual Occupa nd of work done d NOT use retired)		orking		ind of Busines		
ylandz	be filed w ental Hygi 'ked other ic event, t	To Be	17. Father's Name (First, Middle, Last) William Rhodes 1			arco			ame (First, Middle, ae Tyler				,
Mary	2 should th and M 7 is mai traumat		19a. Informant's Name/Relationship (Type, Print)	I				Rural Route Numbe			Zip Code))
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baltimor	permit. Pa Departme Importan any injur,		21. Signature of Funeral Service Licer		GLOVE	22.	Name and Addres	s of Facility Ha	ardesty l Annapolis	Funeı	cal Hon	ne P.	Α.
ŧ	nysician/ Medical		23a. Part 1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ation	not enter	the mode of dying	g, such as cardia	ac or respiratory ar			App Inte	proximate erval Between set and Death
العر	Examiner	iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a						_		-	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):						<u> </u>	
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. DOX	ne death ce / the attenc ched for us	ysician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Wo 9 Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal deat		Ectopic pregnanc Other (specify)	у			23d. Date of o	delivery Day	Year
S, T.O.	uires that th n signed by Ild be deta	ed by Pl	Part II. Other significant conditions	contributing to death bu	_	in the ur	derlying cause giv	ren in Part I.			ise contribute		use of death?
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VICAL	sician: T certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ace of Death (Ch	neck only one)		_		
0 0	iding Phys th. After this funeral di	cate: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day,	nt 2 ER/O / Year) 28b.	utpatient Time of injury	3 □ DOA 28c. Injury work	4 Wind Nursing at	Home 5 Resi			ecify)	
JVISION	al or Atten s after dea il Director: ed in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 1 4 Homicide determined	ne 28e Place of Injur		arm, stre			28f. Location (City or Tou	Street and wn, State)	d Number or F	Rural Rou	te Number,
-	the Hospita in 24 houra the Funera apleted fille	Medical	(Check 2 Medical Exam	vsician: To the best of n niner: On the basis of ex rse Practioner: To the b	amination and/	or investi	gation, in my opinio	n, death occurre	d at the time, date	and place	, and due to th	e cause(s)) and manner stated.
	So With With Co.		29b. Signature and title of certifier		we	>	29c. License	number 5325	55	29d. Dat	te signed (Moi	nth, Day,	Year)
	(0)		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, Pr	int) 2+ex	_ R3	Rices	riot	mi	0 21	1655
e	Stat	te	31. Date filed (Mon OCT Yelr) 2 2		's Signature		ald						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 Bateman Mary Beatrice Fuller October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Bushwood Taylor Farm Assisted Living Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Numbe **Funeral** 1 □ M 2 F Hours Min. Months (Month, Day, Year) 11/10/1923 87 Maryland 220-16-5386 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. Cify, Town or Location Director 1 Yes 2x No Leonardtown Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20650 USA 27983 Point Lookout Road 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Yes, Give White 3 Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fed. Gov't Supply Administrator 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Gwynette Wathen Joseph Grover Ching 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27955 Point Lookout Road, Leonardtown, MD 20650 Joseph Daniel Fuller/Son permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St.Joseph's Catholic | 10/20/2011 Morganza, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P
41590 Fenwick Street, Leonardtown, 21. Signature of Furreral Service Licens 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Myorardial Infarction Physician/ disease or condition resulting in death) Medical Examiner silve to Khri Sequentially list conditions, ue to (or as a consequence of) Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ementia Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death s been signed by the selection should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has b lirector, page 2 sh autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No anistad 26. Place of Death (Check only one) Be 25. Was case referred to medical funeral director, examiner? Other: 4 \square Nursing Home 5 \square Residence 6 $\overline{\mathbf{K}}$ Other (Specify) 2**X** No Living ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work 5 Pending 1 🗌 Yes 2 🗌 No n 24 hours after death. e Funeral Director: A pleted filled in by the fu Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Secritiving Nurse Practioner. To the best of my knowledge. Scatt concurred at the time, date and place, and due to

Registrar

State

Russell

Jeva Russell

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

29c. License number

RO63357

Leonardtown Md. 20650

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34329 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3.20 M 2. Date of Death Month CT Physician/ 11 Ver Medical 4a. Facility Name (if not institution, give street and number) 415 MOLTIPE Db. City, Town, or Location of Death Examiner 4c. County of Death 21661 Chestertown town Nursing > Rehab Kent If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-20 1 🛛 M 2 🗆 F Days Hours Min. Director 29/1928 MD Usual Residence of Deceden an "natural", or items 23a or 28a-f show Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Centreville Oueen Annes 1 🗆 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 330 Hatchett Road 21617 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married SpeBlack 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Menone. Elementary/Seconday (0-12) College (1-4 or 5+) 06 Farm Laborer Private Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oliver Robert Brown Sr. Catherine Powell-Gould 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Brown/Wife 330 Hatchett RD Centreville, MD 21617 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 XBunal 2 Cremation 3 Removal from State Roosevelet Cother place Cemetery 4 Departion 5 ☐ Other (Specify) 10/22/11 Price, MD funeral Service Licens 22. Name and Address of Facility Bennie Smith Funeral Signature. Home 855 High ST Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final 0 ituitarn Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death signed by the a Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hypertension 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 1 🗌 Yes 2 🗌 No Yes or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Wursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Newse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of 29d. Date signed (Month, Day, Year) 101 12/11 3 S 00517 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21620 Tim

DHMH 17 Rev 7/2009

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 7 per fh. 9920 10–27–11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2011 20, Savilla 6:45 Beckman A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13641 Donnybrook Drive Washington Hagerstown . Social Security Number 8. Date of Birth (Month, Day, Year) 1936 West Virginia If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2X F Days Hours **Director** 220-32-3910 Yrs. 75 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13641 Donnybrook Drive 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dale Myers Goldie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Beckman/Husband 13641 Donnybrook Dr., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Smithsburg Crematory 10/22/2011 Smithsburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mente 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only on ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Death Immediate Cause (Final Squamous Physician/ cell lung disease or condition resulting in death) Carcinoma vears Medical Due to (or as a consequence of) **Examiner** Secure fieldy list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Pregnant at time of death Month Day Year 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive Pulmonary Disease Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law cate has page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes s after death. 2 🗌 No Accident
Suicide Investigation 6 Could not be To the Hospital or Atter within 24 hours after der To the Funeral Director completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification D 45563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12916 Conamar Drive Suite 204 Hagerstown, Maryland 21742 THEODORU. M. MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 7 2011

P.O.

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2Day 201^{Year} Cooley 4:40 Beebe A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 13028 Woodburn Drive Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth oct. 29, 1 □ M 2 🗓 F Days 164-36-7952 1945 Pennsylvania Director 65 Usual Residence of Decedent 28a-f show 10a. State 10b. County any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 21 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 13028 Woodburn Drive 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 9 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher 5+ Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Cooley Dorothy Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanford R. Beebe/Husband 13028 Woodburn Drive, Hagerstown, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/26/2011 Rest Haven Cemetery Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or comp ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final Onset and Death Physician/ Metaskh disease or condition resulting in death) mor Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year been signed by the a should be detached t Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 No 1 Yes Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

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(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M'Cornace

State

11110

32. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical

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29d. Date signed (Month, Day, Year)

10.24.11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201°I 6:55 Ам BAUER MARY ANNA LEE October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick
5. Social Security Number Memorial Hospital Frederick If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Hours June 18 (1929) 322-24-1910 82 Introis **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6303 Winpenny Drive 21702 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No
If Yes, Give י "natural", or item ledical Examiner ת Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify Specify: White 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) iii. Page 1 and 2 shours. ... partment of Health and Mental Hygs... ... ant: If item 27 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rene Kempen Leonille Nourie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6303 Winpenny Drive, Frederick, Maryland 21702 Jeff Sonnenberg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o Department of 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg Crematory 10/25/2011 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signatore of Funeral Service Licensee Keeney & Basford P.A. Funeral Home MO1612 Church Street, Frederick, Maryland 21701 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physi i n disease or condition resulting in death) Metastoric melanoma Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been accounted. as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has Director: Director: Dage 2 / performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2XI No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA

Date of injury 28b. Time of 28c 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 - Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signavi and title of certifier D51643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP

Registrar
DHMH 17 Rev 7/2009

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Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,	Last)	Timoth	y Mich				2. Date of Do	Reg. No	av 10	Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, Meritus Medic	-	ber)	.9 0		n, or Location				c. County of	2011 of Death ningt	
Funeral Director		5. Social Security Number 231–33–7150		7. Age (In yrs. la 42	a <i>st birthd</i> ay) Yrs.	If Under 1 Ye Months Da	ear If Under		8. Date of Bi	irth ay, Year)	969	9. Birthp	place (State or Foreign
3	tor	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc	ation			Jan. 1	2, 1			10d. Inside City Limits
e Maryl r 28a-f notifie	Director	Maryland Was	hington			S.	mithsbu	irg		10.0			1 ¥ Yes 2 □ No
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Department of health and Mental Hygiene. The proportant: If time Iz is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	11. Marital Status 1 X Never Married 2 Marr 3 Widowed 4 Divorced	Armed For	2 🔀 No	lf	Yes, specify C	of Hispanic Ori Cuban, Mexicar No Specify:	n, Puerto I	cify Yes or No Rican, etc.)			k, White,	
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permit. Departn Importa any inju		21. Signature of Funeral Service L	icensee	M014	4 -		Idress of Facili	ty <i>J</i>	L. Da				Home and 21783
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Physician/ Medical Examiner		disease or condition resulting in death)	a Due to (c	SEPTI C		as 6	angn	2100					
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To the Hospital or Attending Physician: The law requires that the death certificate be exwithin E4 burns after death. within E4 hours after death. To the Inneral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live E	Birth 2 🔲 Feta nant at time of d	I death 3 🗌	Ectopic pregi Other (specif		_			23d. Date Mor		ery Day Year
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ig Physi er this c neral dir	te: To	1 Yes 2 No 27. Manner of Death	28a. Date o	npatient 2 of injury h, Day, Year)	ER/Outpatient 28b. Time of injury	28c. I	njury at		me 5 Res 28d. Describe				
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the Hos hin 24 ho the Fun npleted	Medical	(Check 2 Medical E	Physician: To the be xaminer: On the basi Nurse Practioner: 1	is of examination	and/or investi	gation, in my o	pinion, death o	ccurred at	the time, date	and place	e, and due	to the ca	use(s) and manner stated.
© 5 4 € 5		29b. Signature and title of certifier	m M	O		-	ense number 126994	6		29d. Da	ate signed	(Month,	Day, Year)
1) 81,		30. Name and address of person v				int)		P. ~	oreter		1	2	-
Stat	te	Emeric Palmer 31. Date filed (Month, Day, Year) OCT 2 7 2011	11116 Me 32. Re	dical C	ampus Fare	<u>na 50</u>	s:1133	nag	CISLOW	11 , FIG	,41/4		
Registra	all .	001 2 1 2011	Maria	- (1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October olema 0505AM 2011 Medical Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death ent ev If Under 7 Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Months Hours Min. MARYLAND Director 071-16-6256 90 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Fleatih and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a f show ther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No KENT CHESTERTOWN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 MORGNEC ROAD 21620 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 XNo ğ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: Completed Year or Dates WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 BOOK KEEPER AUTOMOTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILBERT KENDALL ELIZABETH BELLE ANDERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAROLD COLEMAN 10608 MARBURY CT. AUSTIN, TEXAS 78726 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) SUDLERSVILLE CEMETERY 10/15/2011 SUDLERSVILLE, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN
370 W. CYPRESS ST. 1 & NEWNAM MILLINGTON FUNERAL N. MARYL Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nset and Death Immediate Cause (Final Ph_sician/ disease or condition 121 Medical resulting in death) o sequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has boom along the funeral Director. Cause (Disease or iinjury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2XNo 9 Unknown Unknown Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe the Funeral Director: After this certificate Inpleted filled in by the funeral director, pag Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending 2 Accident M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D0071027 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONTI BROWN ST, CHESTERTOWN, MD 12m 100 ARD 31. Date filed (Month 32. Re strar's Signature State

Registrar

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Ame	nded #	l 0 c	, 10/12/11,	Please	e Type or	Prin	nt in Black	Indeli	ble Ink	k. Ensure A	II Copie	s Are	Legib	le.	
			For State Registrar	, -	State C) IVIE	iryiand / De C	parime ertifica	ite of E	ieaim and i Death	лептат пу		201	1 3	4335
			1. Decedent's Name (Fin	st, Middle, La	ast)						2. Date of De				ne of Death
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	Examin		4a. Facility Name (if not in	, 0		nber)				Location of Death			County of E	Death	
			Chester Riv 5. Social Security Number		nor Sex	7 100	(In um loot hirthdo		nester		Dot of Di		ent	D: 11 - 1 104	
	Funeral Director		220-05-9854 Usual Residence of Dece	4	1 ☐ M 2 🖾 F	92	(In yrs. last birthda Yrs	Month		Hours Min.	8. Date of Bir 1 ^{(M} 27, Pa		Ma.	Country) ryland	ate or Foreign
	and show	ror		o. County			10c. City, Town or	Location		<u>.</u>				10d. Insid	de City Limits
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336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	rces? 2 X e	ver in U.S.	If Yes, sp	ecify Cuba 2 X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		Black, V	American India Vhite, etc. Vhite	n,
9	hours natur fical I	lete	15.	. Decedent's	Education		16a. De	cedent's U	sual Occupa	ation		16b. Kir		ess Industry	
Maryland 21215-0036	within 72 giene. er than " , the Mec	Completed	Elementary/Secondary		grade completed, College (1		-) life	ve kind of v . DO NOT i .tress	ise retired)	luring most of work	ng		od Sei		
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Mai	2 shorth and the shorth and traum		19a. Informant's Name/F					- ·		and Number or Rura		-			
e)	and Healt tem 2		John K. Cr 20a. Method of Disposition		/ 5011		20b. Place of Di			e Barcla	oate			y or Town, Sta	te
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-	Medical Examiner		resulting in death)	•	Due to	or as a	consequence of):)	. 0				6	1
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Box	that the death certificate be ned by the attending physic e detached for use as the bu	Physician/Medical	23b. Was decedent preg in the past 12 montl 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Birth 2 nant at	! Tetal death	3		у		2	3d. Date of Month	f delivery Day	Year
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ta	ysician: The is certificate director, pag	Be	25. Was case referred to examiner?		Hospital:				26. Pla	ace of Death (Check					
Ž	Phys this cral dir	2	1 Yes 2 No		28a. Date		nt 2 ER/Outpa		DOA Othe	4 Nursing Ho	me 5 Resi			pecify)	
n c	nding ath. : After e fune	cate	Natural 5 2 Accident	Pending Investigation	(Mon	th, Day,			work'		zou. Describe i	iow injury	occurred		
Division	al or Attending Physician: The law requires safter death. Director: After this certificate has been sign d in by the funeral director, page 2 should be	Certificate:		Could not determined	be 28e. Place		y - At home, farm, (Specify)	street, fact			28f. Location (City or Tov		Number or	Rural Route N	lumber,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 N only one) 3 C	Medical Exar Certifying Nu	niner: On the bas	is of ex	amination and/or in	estigation,	in my opinio	date and place, an in, death occurred at time, date and place	the time, date a	and place,	and due to	the cause(s) an	d manner stated.
	2 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 ×		29b. Signature and title of	certifier	1		۸. ح	2	9c. License	number	30	29d. Date	1 1	onth, Day, Yea	r)
	4		30. Name and address	f person who	completed caus	e of de	ath (Item 23a) (Typ	e, Rrint)	0 1	<u> </u>		^ -	1)-(4- 5-	
	Rm		treduck 1	Xellan	/ lolat)2	Church	4711	Kel.	Cheste	Mon	INT	211	020	
	Stat Registra		31. Date filed (Month, Da	y, Year)	32. R	egistrar	's Signature	barr	lad						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | | 34336 1 - For State Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last)
Wendel 2. Date of Death 3. Time of Death Physician/ October 1th, 2019 Creighton 11:01 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 12205 Riverview Road Ft. Washington Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 219-34-8269 1 X XM 2 🗆 F Days Hours (Month, Day, Year) 2/05/1937 ^{co}Minnesota 73 Yrs. **Director** Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tes 2XXNo Maryland | Prince George's Ft. Washington 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 12205 20744 Riverview Road within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 \times Yes 2 \square No 19 If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ö ģ 1 Never Married 2XXMarried 1959 Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify. 'natural", 3 Widowed 4 Divorced Specify Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Broker Real Estate Be 17. Father's Name (First, Middle, Last) William F. 18. Mother's Name (First, Middle, Maiden Surname) Creighton ၉ Forrest Marie Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Creighton / Wife 12205 Riverview Rd. Ft. Washington, Maryland 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 KKremation 3 Removal from State 10/13/2011 Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? been signed by the atte should be detached for Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? certificate Yes 2 X ONC 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 1 Tyes Other: 2X X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) To the Hospital Medical 1XX&ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician RONALD EARL COLLINS 11:45 AM 10 8 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S BRADFORD OAKS SENIOR HOME CLINTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Director 577-50-7247
Usual Residence of Decedent 74 1937 DC JULY 18, 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1XYes 2 No Director MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 12011 GREEN TEE TURN 20772 UNITED STATES permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Mydical Examiner intest once. items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mores 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SPECIAL POLICE OFFICER DC GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl L. Collins Eunice V. Tibbs ပ 19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12011 Green Tee Turn Upper Marlboro, MD 20772 19a. Informant's Name/Relationship (Type. Print) Randall M. McNealy/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans 20a. Method of Disposition 20c. Location - City or Town, State 10/11/2011 1 ☐ Burial 2 X Cremation 3 Removal from State 4□Donation 5☑Other (Specify) Inurnment Cheltenham, MD at Cheltenham Cemetery 21. Signature of Funeral Service Lig 22. Name and Address of Facility Pope Funeral Homes, PA 5538 Marlboro Pike, Forestville, MD 20747 M01085 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 141.05 der stic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Dav 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2XNo 24a. Was an certificate 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 ♣0 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident neral Director: , filled in by the f 6 ☐Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier I puna m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingin Rond , Ent WAS HINGTON MANGES pund Illim M-Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 09 2011 homas Medical hen 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 7. Age (In yrs, last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🗶 M 2 🗆 F Months Days Hours Min. **Director** 579-46-2396 Washington DC Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Directo District of Columbia 1 X Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3700 9th Street SE #430 20032 United States ral", or items ; Examiner mu: Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes f Yes, Give 2 □ No Army Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 Widowed 4 X Divorced **Black** Unk Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Eleventh Private None Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Carthens DAisy Hackett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3700 9th Street SE #430, Washington DC 20032 Gloria Carthans/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | Unknown Beltsville Maryland 21. Signature Donald R. Gray 22. Name and Address of Facility Robert G Mason Funeral Home Inc 1661 Good Hope Rd SE Washington DC 20020 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1 Enter the disease, or complication of leart failure. List only one Interval Between Immediate Sause (Final Onset and Death Ph sician/ disease or condition SIS Medical resulting in death) Examiner LEG Sequentially list conditions, Due o (or as a conse dence of): if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 2 No detached 9 Unknown Unknown s been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No funeral director, page 2 Huper this certificate 2 X No 1 Yes 25. W case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🗌 No Other: 1 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? s after death. 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident filled in by the Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34339 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCT. 20, 2011 CLAIRE ARLENE CALLAHAN 9:55A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHARLES MORNINGSIDE HOUSE WALDORF 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
11-1-1924 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 - M 2 F Min. 86 **Director** 037-12-8303 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CHARLES 1 🗌 Yes 2 🔀 No MD. WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 70 VILLIAGE STREET 20602 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced SpecifyWHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) H (MEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN J. TOOLE KATHRYN UPTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 ROSSLARE CT. ARNOLD, MD. 21012 JOHN K. CALLAHAN-SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State METROPOLITAN CREMATORY 10-22-11 4 ☐ Donation 5 ☐ Other (Specify) ALEX., VA. 21. Signature of Funeral Service Licenses MQ0479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 PLATA, MARYLAND 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ement, a Seni Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has irector, page 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 [မြ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 \square Pending s after death. M 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

31. Date filed (Month, OCT 2

29b. Signature and title of certifier

30. Name and address of person who

2011

within 2

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State		State of	f Marylan				d Mental H	ygiene 21		34340
		Registrar 1. Decedent's Name	e (First Middle	Last)		Cer	tificate of I	Death	2. Date of I	Reg. No.	7 1 1	
Physicia Medic		Alice	BI	Durst					Month	O Day	Zoll	3. Time of Death 3.29 AM
Examin			r	give street and num	- 1	27	4b. City, Town, o		eath	4c. Count	. ,	
Funeral		5. Social Security N		and Reha	6 Cent		OaK/a If Under 1 Year	nd If Under 24 H	Hrs. 8. Date of E		9 Birthol	lace (State or Foreign
Director		215-82-9	,	1 🗆 M 2 🗗 F	92	Yrs.	Months Days	Hours M		Day, Year 19/8	Mary	land
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Maryla 28a-f s otified	rect	MD	Garre	tt	Swar	nton						1 🗆 Yes 2 💆 No
with the 23a or 2	Funeral Director	10e. Street and Nun		e Rd.			10f. Zip Code 21561			10g. Citizen of USA	What Count	ry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	oy Fun	11. Marital Status 1 ☐ Never Marri	ied 2 🗆 Marri	12. Was Deced	ces?	If	Yes, specify Cub	an, Mexican, Pu	(Specify Yes or Nierto Rican, etc.)		ce - America ick, White, e	
ours aft tural", al Exa	Completed by	3 🛚 Widowed		If Yes, Give Year or Da			Yes 2 X No			Specify	Whit	:e
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2 should lith and N 27 is ma r trauma		19a. Informant's Na		_{ip (Type, Print)} y/Daughte	r				Rural Route Num	ber, City or Town,	State, Zip G	ode)
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it. Pag intment intant: njury c		4 Donation	5 Other (S)	pecify)			emetery			ll Grant neral Ho		
permir Depar Impor any ir		21. Signature of Fu	Mctt	pensee A	خف				antsvill		21536	L •A•
		23a. Part 1. Enter the shock, or hear Immediate Cause (rt failure. List o	complications that can ally one cause on each	aused the deat ch line.	h. Do not ente	r the mode of dyir	ng, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)		a. Due to (c	or as a consequ	uence of):	an	thites	dos	is a		yezvs
Examiner	Ţ.	Sequentially list co	nditions.	b. ———								
ted nsit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	rlying iinjury	Due to (d	or as a consequ	uence of):						
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Physic this corral dire	2	1 Yes 2		Hospital:	npatient 2	ER/Outpatien	t 3 DOA Oth	4 Nursin		sidence 6 🗆 Oth		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	∴ Medical E	Physician: To the be caminer: On the basi Nurse Practioner: 1	s of examinatio	n and/or investi	igation, in my opini	ion, death occurr	ed at the time, dat	e and place, and di	ue to the cau	se(s) and manner stated.
To the	2	29b. Signature and		. Û	o the best of th	y Milowiedge, d	29c. Licens			29d. Date signe		
	,	30. Name and addre	ess of person w	ho completed cause	e of death (Item	23a) (Tvne. P		5005	77	10	0/2	, - 01
	1	Thomas J	ohnson	311 N. 4	th Str	eet, Oa		4D 2155	50			
Stat Registra		Date filed (Monti	h, Day, Year) T 112	32. Re	egistrar's Signa		w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34341 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Mary Gertrude Drury 2011 October Medical 8:42 P M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 37925 New Market Turner Rd. Mechanicsville Mary's Social Security Number **Funeral** . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🕱 F Months Days Hours Director (Month, Day, Year) 12/20/1933 579-48-4376 77 Washington. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland St. Mary's Mechanicsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37925 New Market Turner Rd 20659 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 Yes 2 X No "natural", If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 🛛 Widowed 4 🗌 Divorced Completed White Specify: other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+ 12 Insurance Underwriter Be Insurance permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Russell Rusmisel <u>Mautie Mola Kincaid</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis R. Rose/Daughter 13640 Padgett Ct., Charlotte Hall, MD 20622 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem.Gardens 10/21/2011 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) oronan Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated see or iinjury Examiner Due to (or as a consequence of): death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a cons physician Physician/Medical Division of Vital Records, P.O. Box 68760 ed by the attending p detached for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has 24a. Was an autopsy performed Yes 2 the Hospital or Attending Physician: The hin 24 hours after death, 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ဂ 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending injury Director: / Accident Investigation 1 Yes 2 No completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, in 24 hou. the Funeral D City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within To the 29b. Signature and title of certifier 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print

State

Registrar

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Brian Edward Dicke		on - For State	St	ate o	f Maryla			tment of			Menta	al Hyg			20	1	1 3434
Physician		egistrar . Decedent's Name	(First, Middl	e.Last)			OUT	meate of	Doa			2	. Date of De	Reg. No ath).		3. Time of Death
Medical Examine	4	Brian Ed			erson								Month October 8	Day 3, 201	Year I1		2035 hrs
	4	a. Facility Name (if				ımber)		1	4b. City,	Town, or L	ocation of				c. County of E	eath)	
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Funeral		5. Social Security N	umber	6. Sex		7. Age (In	yrs. las	t birthday)		der 1 Year	If Under		8. Date of B	irth(MN		9. Birth oreign	place (State or
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica		17. Father's Name (. 1							,			n Surname)	_	
d be fill fental Franked event,		Alfred F				son		19h Mailin	a Addres					_	ckerson		Zin Code)
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland this and Mertal Hygiene at 127 is marked other than "natural", or items 23a or 28a-f she unmatic event, the Medical Examiner must be notified at once To Re Commissed by Filmeral Director		Nancy R.				ther		4		,					wn, MD		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the preparent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be To Re Commissed by Elimers.	- 1	1 Burial 2			Removal f	rom State		ematory or ot esapeal	,		100	10/	10/201	1 0	tevens	1	1a MD
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Divisior Brospital or Attend 24 hours after death Francral Director: rety filled in by the	5	4 Homicide	dete	rmined	(Specify	()										_	
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physomethety filled in by the funeral director, page 2 should be detached for use as the bediened of Cartification. To De Completely the Directorian Management of the physician Research of the physi	<u>ह</u>	29a. Certifier 1 (Check only one) 2													and manner a place, and du		
To the within To the complet	Medical	29b. Signature and			and manner					9c. License							nth, Day, Year)
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	-	39 Name and addr	ess of person	e le	ompleted ca	use of deat	th (Item	23a)						\perp			
		Laron Locke						900 W. B	altimo	re Street	t, Baltim	nore, M	ID 21223				
Sta		31. Date filed (Mon	th, Day, Year			Registrar's	Signatu	re A		1							
Registra	ar		UCI 1	2 2		Deserve	-	B. A	arke								

ORIGINAL

Amendment, 2			Pleas	e Type or Pri					•		•	e.
Per Physicia 10/06/11 cm	ın .	For State Registrar		State of M	aryiano		artment of tificate of		ı Mental H	ygiene Reg. No	201	1 34343
Physiciar Medic		1. Decedent's Name Ruth	e (First, Middle, L Delana		er				2. Date of D	eath 4^{2}	ay 201	3. Time of Death
Examine		4a. Facility Name (if WM. Regi	not institution, gi onal Med	ve street and number) lical Cente:	r		4b. Gity, Town,	or Location of De erland	ath	40	County of De Allegar	eath ly
Funeral Director		5. Social Security No. 235–50–0			e (In yrs. las 77	st birthday) Yrs.	If Under 1 Year Months Days				34 We	Birthplace (State or Foreign Stronia
aryland a-f show fied at	ector	Usual Residence of 10a. State MD	10b. County Allega	ny		Town or Loc						10d. Inside City Limits 1124 Yes 2 □ No
vith the M 23a or 28 st be noti	Funeral Director	10e. Street and Nun	nber rst St.				10f. Zip Code	1562			tizen of What	Country?
, <u></u>		11. Marital Status 1 Never Marri 3 Widowed		12. Was Decedent E Armed Forces? 1 Yes 2 II If Yes, Give Year or Dates.		l If	√as Decedent of Yes, specify Cub	Hispanic Origin? (pan, Mexican, Pue o Specify:	Specify Yes or No erto Rican, etc.))-	Black, Wi	nerican Indian, nite, etc. vhite
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", on my injury or other traumatic event, the Medical Examatore.	e Completed by	Elementary/Second 12	onday (0-12)	College (1-4 or 5	+)	(Give k life. DC	ent's Usual Occu ind of work done O NOT use retired rdresse	during most of w	orking		auty Sa	
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imore Page 1 a ment of H ant: If ite				Removal from State	20b. Pla Phi	ace of Dispos metery, crem LOS C6	sition (Name of latory or other pla emetery	^{ace)} 10/	09/2011	Wes	ocation - City ternpo	or Town, State rt Maryland
Balt permit. Depart Import any inj once.		21. Signature of Fur	eral Service Lice	Sil				ess of Facility B				ī 21562
Phylician Medical Examiner		23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List only Final	mplications that caused one cause on each line a. Due to (or as a	+1+/	460	the mode of dy		ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
60 ate be executed hysician and the burial-transit	dical Examiner	Sequentially list cor if any, reading to fin cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	lying injury	b. Sure to (or as a Due to (or as a d.					Qa.	0//	A non	10/5/11
Box 68760 The death certificate be the attending physicic check of the attending physicic check for use as the but		F FEMALE: 23b. Was decedent p in the past 12 n 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome of 1 Live Birth 2 Pregnant at 9 Unknown	2 Fetal	death 3 🗌	Ectopic pregnar Other (specify)	псу			23d. Date of o	delivery Day Year
ords, P.O. B	Completed by Pl	Part II. Other signif i	cant conditions	contributing to death bu	ut not resul	iting in the ur	derlying cause g	iven in Part I.		Yes 2	② No 3□	to the cause of death? Probably 4 Unknown autopsy findings available
/ital Reco	Re	25. Was case referre examiner 1 Lives 2 □		Hospital:				Place of Death (Ch	auto perl 1 Yes	opsy formed? 2 10	prior t death	o completion of cause of ? ? es 2 No
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the Hospita thin 24 hours the Funeral	Med	(Check 2		ysician: To the best of r niner: On the basis of ex rse Practioner: To the b	ny knowled amination a pest of my k	and/or investig	gation, in my opin eath occurred at t	ion, death occurre	and due to the c	ause(s) an and place	nd manner as s	stated. e cause(s) and manner stated.
→ 5.≥ 5.8) M	Mu	WA	<u> </u>	-m	1 29C. Licens	OS3/	58	29d. Dai	te signed (Moi	nth, Day, Year)
				completed cause of de	ath (Item 2	(3a) (Type, Pr	int).	rile	ana	6-11	600	/ md
State Registrar		1. Date filed (Month	CT 0 6 2	011 32. Degistrar	's Signatur	1 40	wed					

must be "natural", or iter within 72 hours after Maryland 21215-0036 the Medical I Hygiene. 2 should be filed the and Mental H 27 is marked of traumatic ever

certificate be executed attending physician ģ Records, certificate or Attending Physician: of Vital this Division

For State Registrar 34344 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 201 T 7:20 A. M Sarah Lee Staton Fortune 0ctober 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Days Hours Min March 28,1932 North Carolina 79 Yrs Director 579-42-6748 Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No District of Columbia Washington 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 20017 1013 Upshur Street, N. E. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married **Black** If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Armed Forces Retirelife. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ment Home-Washington Chef 10th grade Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ೭ Wast Staton Henritta Lynch permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is markel any injury or other traumatic ence. 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Julius Fortune, Jr. 1013 Upshur Street, N.E.; Washington, D.C. 20017 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Oct.15,2011 4 Donation 5 Other (Specify) Washington Cemetery Adelphi, Maryland Signature of Funeral Serv 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TI Physician/ disease or condition / Medical resulting in death) as a consequence of) ANTENY DISEASE Examiner CORDNAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exami bunal-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð HYDERTENCION 1 Yes 2 Wo 3 Probably 4 Unknown Completed MABETET MELLITUS TYPE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 JUNO 1 Tes ၉ 1 Impatient 2 I ER/Outpatient 3 I DOA funeral 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🕒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a d title of 29c. License numbe 29d. Date.signed (Month. Day, Year, 201 10/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID WASHIR WASHINGTON ADVENTIST the PITAL, TAKOMA (M) 127521C, MD-2091 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mason Medical Granville Goldsmith October 2011 7:30 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 17311 River Airport Rd. Brandywine Prince Georges **Funeral** Social Security Number . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 🗆 F Director 09/26/1920 Hours 218-36-2760 91 Yrs Maryland Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland| Prince Georges 1 🗆 Yes 2 🗶 No Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 17311 River Airport Rd. 20613 U_S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. injury or other traumatic event, the Medical Examiner Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. "natural", If Yes, Give Year or Dates Completed 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Farmer Be Agriculture 17. Father's Name (First, Middle, Last) should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ည thent of Health and Mertant of Health and Mertant: If item 27 is mark Granville R. Goldsmith <u>Frances Elizab</u>eth Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joseph R. Goldsmith/Son</u> 17300 River Airport Rd., Brandywine, MD 20613 permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Trinity Mem. Gardens 10/19/2011 | Waldorf, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Onset and Death Medical Due to (or'as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown signed by the Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 \sum Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗆 Yes Hospital 2 🖳 No 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) after death. work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TO DU.

Registrar

DHMH 17 Rev 7/2009

State

Mukesh N. Mathur, M.D.,

OCT 18 2011

Suite 305, 110 Hospital Rd., Prince Frederick, MD 20678

P.A.,

11-07380 Sharon Patricia Gale Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar					Certif	icate of	Death			F	teg. No.			
Physicia	ın/	1. Decedent's Nan									1	2. Date of Dea		Yea	,	3. Time of Death
Medical Examir	ner		ron Pa				2					Month October 2				0657 hrs
		4a. Facility Name 5206 Newto		on, give s	street and n	umber)		4	b. City, Town, o Bladensbu		of Death			County of		's
Funeral		5. Social Security		6. Sex		7. Age (In yrs. last l	birthday)	If Under 1 Ye Months Da		der 24Hrs.	8. Date of B	rth(MM/D	D/YYYY	9. Birtl Foreign	hplace (State or
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JIMOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Fleath and Mental Hygiene. State: If litem 27 is marked other than "matural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	5206 No		Str	coot	#202)		20710				-	en or vvn	at Coun	try ?
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	-	30. Name and addr	ess of person	who con	npleted caus	e of deat	h (Item 23a)	.l				<u> </u>			
		Ana Rubio I	=					,	ore Street,	Baltimo	ore, MD	21223				
Sta	te	31. Date filed (Mont	h, Day, Year)	6	32. Re	cistrar's	gnature	j								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34347 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 HANGZHOU GUO October :45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 23, 1 9. Birthplace (State or Foreign Country) **Funeral** 1 **₹** M 2 □ F Days Hours Min. Director 474-17-6935 China Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 3902 Aberdeen Way 21704 IISA permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 Widowed 4 Divorced Chinese 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Software Engineer Computer Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bin Han Guo Mei Zhuang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Guo - Daughter 445 East North Water St., Chicago IL 60611 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important; If ite any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 23, 2011 Smithsburg, Maryland 21. Signature of Funeral Savice I 22. Name and Address of Facility Keeney & Basford Funeral Home MO1433 106 E. Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be east hours after death.
Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 1 Yes 2 N funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, MDD67750 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ampol

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b Per FH G928 6/20/2012 JH State of Maryland / Department of Health and Mental Hygiene 20 34348 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monto/10/2011 Opal Marie Hill 0720 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) 4/23/1921 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1 🗆 M 2XX VA **Director** 90 225-01-5462 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director Prince George' 1XXYes 2 No Anne Arundel Beltsville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 20705 4812 Naples Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces Black, White, etc. ŏ ρ 1 Never Married 2 Married 1 ☐ Yes **¾¼** No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 ☐ Yes XX No Specify: "natural", Completed ¾X Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarissia Moubray William Gladwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21401 767 Bon Haven Drive Sandra Ross Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Mem Gardens 10/15/2011 Harrisonburg, VA 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Euneral Service Licenses Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on such line. Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence oi). or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) To the Hospital or Attending Physician: The law requires that the dee within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing t**o/**death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes No 1 Yes No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 ☐ No ၉ 2 PER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pendina 1 Yes 2 No М ☐ Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3

3 29b. Signature and title of e

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Registrar DHMH 17 Rev 7/2009

State

License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0642 M 09 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin Chesapeake Hospice House Harwood 6. Sex Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, 06/06) 1 M 2 1 82 Director 174-24-2505 1929 Pennsv1vania Usual Residence of Decedent show 10b, County 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🕅 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 USA 3621 7th Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 V No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carl Massung Allie Fretts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terrance J. Higdon, Sr. / Son 3463A Shady Drive, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Donation injury 5 Other (Specify) Lakemont Mem. Gardens: 10/12/2011 Davidsonville, MD rvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature MD 21037 Edgewater, 2973 Solomons Island Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On Ind., e.in Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law "equires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Fecords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Year Month Day Pregnant at time of death g Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 6 Other (Specify) MANDRIN Certificate: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural 1 Yes 2 No Accident Investigation □ Accider □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of pers use of death (Item 23a) OR CNEVIEW 31. Date filed (Month, Day, Year) State 12 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar		ar y rarr		tificate of				Reg. No	ZUI	34	350
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1	Examin	er					Callawa		Ji Death			t. Mary		
	Funeral		20990 Hunting Qu 5. Social Security Number 6.	. Sex 7. Age		ast birthday)	If Under 1 Year	If Under		8. Date of Bir	th	9. B	rthplace (State of	o <i>r Forei</i> gn
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Maryland 21215-0036	ould I		19a. Informant's Name/Relationship			19h Maili	ng Address (Stree	-	•			Town, State, Z	'in Code)	-
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Baltimore,	permit. Page 1 Department of Important: If i any injury or conce.		21. Signature of Coneral Service Lies)	22	2. Name and Addr	ess of Facilit	y Bri	nsfield	d Fu	neral H	lome, P.	Α.
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Pox	e deat the at hed fo	Physician/	1 Yes 2 No 9 X Unknown	4 ∐ Pregnant a 9 ☐ Unknown	t time of c	death 5 L	Other (specify)					Month	Day	Year
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<u> </u>	Physi this c	2	1 Yes 2 No 27. Manner of Death	1 Inpatie		ER/Outpatie	nt 3 🗆 DOA					6 Other (Spe	ecify)	
10 U	ding th. After funer	cate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Day	v, Year)	injury	wo		. 1	28d. Describe	now injur	ry occurrea		
DIVISION	Atten er dea ector: by the	Certificate:	3 Suicide 6 Could no	ot be 28e. Place of Inju			eet, factory, office						ural Route Num	ber,
2	ital or irs afte al Dir led in			building, etc	з. (Бреспу,	"			. 1	City or To	wn, State	=) 		
	To the Hospital or Attending Physician: The law requires that the death certival to 4 hours after death to the within 24 hours after death this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of e	xamination	n and/or inves	tigation, in my opir	nion, death of	ccurred a	the time, date	and place	e, and due to the	e cause(s) and ma	anner stated.
	ormplk	Ž	only one) 3 ☐ Certifying N 29b. Signature and title of certifier	lurse Practioner: To the	best of my	y knowledge,		he time, date se number	and plac	e, and due to th		s) and manner a ate signed (Mor		
			* Xm	4~				597	•			-13 -11		
ク	ene		30. Name and address of person wh	o completed cause of d	eath (Item	1 23a) (Type, F					-			
9			Jeffrey C. Brow	m, M.D. 2	6840	Point	Lookout	Road,	Lec	nardto	wn,	MD 206	50	
	Stat Registra		31. Date filed (Month Pa), Year	2011 32 gjistra	ar's Signat	ture.	have							

			Please	Type or Pri							gible.	
		-	For State	State of M		-	rtment of F tificate of L	Health and N Death		giene Reg. No. 2	011	31,351
			Registrar 1. Decedent's Name (First, Middle, La	st)		001	imouto or E	-	2. Date of Dea	ith	V	3. Time of Death
	Physicia Medic				uise	Hu	miston		October		011	12:20 _p м
	Examiner 4a. Facility Name (if not institution, give street and number St. Mary's Hospital						**	Location of Death rdtown	th 4c. County of Der St. Mary			s
	Funeral Director	5. Social Security Number 288−12−0384 6. Sex 1 □ M 2X F 7. Age (In yrs.				<i>nday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 9. Bi (Month, Day, Year) 12/3/1921			place (State or Foreign htry) Ohio
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation					10d. Inside City Limits
	Maryla 28a-f s stified	rect	Maryland St. Ma	ry's	Ca1	lifo	rnia					1 ☐ Yes 2 🔀 No
	s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	Funeral Director	10e. Street and Number 44013 Flagston	e Wav			10f. Zip Code	20619		10g. Citizen o	f What Coul	ntry?
	items		11. Marital Status		2. Was Decedent Ever in U.S. 13. W			ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-			
Maryland 21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No		Yes 2 No				ack, White, fy: Whi	
15-(72 hou n "nat Aedica	Completed	15. Decedent's E (Specify only highest g	rade completed)		(Give k	ent's Usual Occup ind of work done of NOT use retired)	during most of work	ing .	16b. Kind of	Business In	dustry
212	within giene. er tha t, the I	COI	Elementary/Seconday (0-12)	College (1-4 or 5	College (1-4 or 5+)				H		lealth Care	
and	e filed ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)	Last) Harry E. Stewart			18. Mother's N			Maiden Sumai Hanso		
aryla	ge 1 and 2 should be filed within 72 hour it of Health and Mental Hygiene. If item 27 is marked other than "natuu or other traumatic event, the Medical		19a. Informant's Name/Relationship (Mailin	g Address (Street	and Number or Rur	-			Code)
			Homer A. Hum	iston/Husb				tone Way	, Califo			
nore	age 1 a ant of H rt: If ite y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		cemeter	y, crem	sition (Name of atory or other place		Date 9 / 2 0 1 1	20c. Location	•	
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		4 Donation 5 Other (Specify) 21. Signature of Fune Service Licensee David A. Goff Metropolitan 10/18/2011 Alexandria, 22. Name and Address of Facility Mattingley—Gardiner Funeral Home, P. 41590 Fenwick Street, Leonardtown, M									
			23a. Part 1. Enter the disease, or con	plications that caused	A. Gof						own,	Approximate
	h sician/	Š (4)	shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line	enal	Fa	lures					Interval Between Onset and Death
Ç.	Medical Examiner		resulting in death) Due to (or as a consequence of): Respiratory Foul use									
		Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as	as a consequence of): espiratory failure as a consequence of): He mant failure							
	executed an and rial-transi	Exar	resulting in death) Last Due to (or as a consequence of):								<u>. </u>	
09,	ate be o	dical		d	Sar	(0	ma		-			
Box 68760	Attending Physician: The law requires that the death certificate be executed at death. The death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	Ectopic pregnance Other (specify)				23d. Date of delivery Month Day Year				
P.O.	that the ned by detac	y Ph	Part II. Other significant conditions	contributing to death t	out not resulting in	n the ur	nderlying cause giv	ven in Part I.	23e. Did to	bacco use co	ntribute to t	he cause of death?
.qs	equires en sign	ted b								1 Yes 2 No 3 Probably 4 Unknow		
ecol	e law re e has be ige 2 sh	ample								rmed?	prior to co death?	ppsy findings available empletion of cause of
a B	ian: Th rtificati xtor, pa	Be Co	25. Was case referred to medical examiner?				26. PI	ace of Death (Chec	1 L Yes	2 X No	1 Yes	2 ⊔ No
Vit.	hysica this ce	욘	1 ☐ Yes 2 No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi				4 L Nursing H	Home 5 Residence 6 Other (Specify)			
o u	nding F ath. : After t	cate:	27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M				?	28d. Describe how injury occurred			
Division of Vital Records,	Hospital or Attendi 24 hours after death, Funeral Director: A eted filled in by the fu	Certifi	3 Suicide 6 Could not 1 4 Homicide determined	be 28e. Place of Inju	Se. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number City or Town, State)			l Route Number,
_	To the Mospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should	Medical Certificate:	(Check 2 Medical Exam	ysician: To the best of niner: On the basis of e	xamination and/or	r investi	gation, in my opinio	on, death occurred a	t the time, date a	nd place, and	due to the ca	ause(s) and manner stated.
	To the within to the complete		29b. Signature and title of certifier	rali			29c. License number 29d.			29d. Date sigr	I. Date signed (Month, Day, Year)	
			30. Name and address of person who	completed cause of r	leath (Item 23a) (I	Type. P		71000		1	0 (1	. 1
0	eme		Avani D. Shah,	M.D. 22650	Cedar I	Lane	Court,	Leonardt	own, MD	20650		
Silv	Sta Registra		31. Date filed (Month, Day, Year) OCT 1 8 20	3. Registra	ar's Signature	for	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Dep	artment of Health and M rtificate of Death	lental Hygiene							
	Registrar CE	Reg. No	g. No.							
Physician/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month October 17	3. Time of Death 7, 2011 10:50 a.m.						
Medical Examiner	Thomas George Hodges 4a. Facility Name (if not institution, give street and number)	OCCUPUL IN	7, 2011 10:50 a.m.							
LAMITIME	St. Mary's Hospital	4b. City, Town, or Location of Death Leonardtown		. Mary's						
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign						
Director	217-36-7523 TW Pris. Usual Residence of Decedent		(Month, Day, Year) 05/29/1932	2 Maryland						
thow at	10a. State 10b. County 10c. City, Town or Lc	cation		10d. Inside City Limits						
ne Maryland or 28a-f sho notified at	Maryland St. Mary's Avenue			1 ☐ Yes 2 🛣 No						
a or 2	10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?						
eath with ti items 23a e er must be Funeral	39325 Burch Road	20609		ted States						
r deat	Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc. 						
036 s after c Examir ed by	1	1 🗌 Yes 2 ဳ No Specify:		Specify: White						
5-0 hour	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of workir	16b. F	Kind of Business Industry						
1215-003 rithin 72 hours af fene. r than "natural" the Medical Exa	Elementary/Seconday (0-12) College (1-4 or 5+)	O NOT use retired)								
d 21 led wit Hygie other: ent, th	11 Farme		(First, Middle, Maiden	rming						
Maryland 21215-0036 2 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Edwin Joseph Hodges		ene Hayden	Cumamy						
ary nould ind M s mar		ng Address (Street and Number or Rural		r Town, State, Zip Code)						
nd 2 s nd 2 s seatth a n 27 i	Mary Hodges/Wife 39325	Burch Road, Avenu	ie, MD 206	609						
nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	20a. Method of Disposition 20b. Place of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crei	osition (Name of Datory or other place)	ate 20c. L	Location - City or Town, State						
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe once.	4 □ Donation 5 □ Other (Specify) Charles N	<u> 10/22 (emorial Cem</u>		nardtown, MD						
Baltimo Baltimo permit. Page Department of Important: If any injury or	21. Signature of Puneral Service Likensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Faward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650									
30 20 2 8 9	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between						
Physician/ Medical	Immediate Cause (Final disease or condition resulting in death) a. District Cares 7 a. District Cares 7									
Examiner	Due to (or a /a consequence of):	«								
TA a	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):									
ecuted and al-transit	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.									
60 ate be executed obhysician and the burial-transit	resulting in death) Last Due to (or as a consequence of):									
760 rate be exphysician the burial	d									
687 687 certifica nding p use as i	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	7		23d. Date of delivery						
30x Seath death of for the sicial	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Live Birth 2 ☐ Fetal death 3 L ☐ Pregnant at time of death 5 [Other (specify)		Month Day Year						
O. For the contraction of the co	y 🗆 Unknown	underhiber seven ships in Dark I		use contribute to the cause of death?						
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the IE Ch this Jaj.	andenying cause given in Part i.		No 3 Probably 4 Unknown						
aw req			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
Rec The k			performed?	death?						
ician:	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)							
Physical directions of Vi	1 Inpatient 2 ER/Outpatie 27. Manger of Death 28a. Date of injury 28b. Time o	nt 3 □ DOA	me 5 Residence (28d. Describe how inju							
on C nding ath. :: Afte e fune	1 ☑ Natural 5 ☐ Pending (Month, Ďay, Year) injury 2 ☐ Accident Investigation	work? M 1 🗆 Yes 2 🗀 No	.ou. poorting from the	.,,						
Division of Vital Records, all or Attending Physician: The law requires s after death. In Director, After this certificate has been signed in by the funeral director, page 2 should be all by the funeral director, page 2 should be all by the funeral director.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)						
he Hospital in 24 hours he Funeral ipleted filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigation)	occured at the time, date and place, and stigation, in my opinion, death occurred at	d due to the cause(s) a	and manner as stated. e, and due to the cause(s) and manner stated.						
o the h vithin 2 fo the f	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
	MUMO Allhligh. MO.	D060473	10,	117/2011						
5 Rme		opital Leoners	foun, ~	10 20650						
State Registrar	31. Date filed (Month, Day, Year) 0CT 1 9 2011 32. registrar's Signature.	ace								

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		For State		State of Ma	arylan	_	artment of F		dental Hy		0 0 1	01050	
		Registrar 1. Decedent's Name (First	t, Middle, Last)					Catil	2. Date of De	Reg. No eath	201	3. Time of Death	
Physicia Medic		7	HELM	NA	HA	WS	LEY		Month (0	5 5	ay Year 2011	9:30 PM	
Examin		4a. Facility Name (if not in.	stitution, give str		- Ci	NES		Location of Death	E	40	c. County of Deat	h 7	
Funeral Director		5. Social Security Number 213–16–6976	1 🗆	M 2 🏞 F 7. Age	e (In yrs. Ia 96	s <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept •		9. Bird 1915	hplace (State or Foreign unity) Virginia	
ıryland a-f show fied at	Funeral Director		County		10c. City	, Town or L	ocation	Washing	ton			10d. Inside City Limits 1 ★ Yes 2 □ No	
or 28		DC 10e. Street and Number					10f. Zip Code	WABIITIIG		10g. C	itizen of What Co	untry?	
with t	eral	829 10th S	treet N	E				20002			United S	States	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۵	11. Marital Status 1 ☐ Never Married 2 3 ☒ Widowed 4 ☐ □	☐ Married	2. Was Decedent E Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates.		. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - Ame Black, White Specify: B		
hin 72 hour ne. than "natu ie Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)			i+)	(Give kind of work done during most of working life. DO NOT use retired)					Kind of Business	·	
ed with Hygier other I	BeC	8th 17. Father's Name (First, Middle, Last)					Day Care	18 Mother's Nam	ne (First, Middle, Maiden Surname)			enc	
be fill lental rked c	卢	,	Jim Mo	ody					Arlene	,	unk.		
should and M is mai		19a. Informant's Name/R	elationship (Type	, Print)		19b. Mail	ling Address (Street a	and Number or Rura	al Route Numbe	mber, City or Town, State, Zip Code) 20772			
nd 2 s ealth m 27 ner tra		Daniel Asef		andson			Pensacol	a Place	Upper				
t. Page 1 a tment of H rtant: If ite jury or oth		20a. Method of Dispositio 1 🛂 Burial 2 🗌 Cre 4 🔲 Donation 5 🗌	emation 3 🗌 Re Other (Specify)	emoval from State	Ce	emetery, cre aryla:	osition (Name of ematory or other place nd Nationa	a1	ber 15, 2011	1		Maryland	
permir Depar Impor any in		21. Signature of Funeral S	Service Licensee	Stowa	NT,=		22. Name and Addres 1001 Benni					, inc. 20019	
ysician/ Medical		23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or complic re. List only one	ations that caused cause on each line) D	n. Do not en						Approximate Interval Between Onset and Death	
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rtifical ling ph e as th	/Mec	IF FEMALE:	00	o lé uso subsesses		-0.7				Ī			
t the death ce by the attend tached for us	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown					☐ Ectopic pregnand ☐ Other (specify)	ЭУ		23d. Date of delivery Month Day Yea			
uires that the signed by all he detact		Tark is Other significant contained a contained in part not recounting in the analyting season great in the contained in the								23e. Did tobacco use contribute to the cause of death			
: The law require: cate has been sig page 2 should k									24a. Was auto perf 1 \(\sum \) Yes	opsy ormed?	prior to	topsy findings available completion of cause of	
iding Physician: The th. After this certificate funeral director, pag	Be	25. Was case referred to rexaminer?	_	spital:			26. Pl	ace of Death (Chec	k only one)	/\			
Physic this cral din	. To	1 Yes 2 No 27. Manner of Death	110	1 Inpati		ER/Outpation	ent 3 L DOA	4 Nursing Ho			6 Other (Spec	cify)	
nding ath. : After e fune	icate	~	Pending Investigation	(Month, Day	y, Year)	injury	work		200. 20001150	how injury occurred			
o the Hospital or Attending F within 24 hours after death. To the Funeral Director: After to completed filled in by the funeral.	Certificate:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)					treet, factory, office			n (Street and Number or Rural Route Number, Town, State)			
Hospit 4 hour Funers	Medical	(Check 2 DM	edical Examine	r: On the basis of e	xamination	and/or inve	occured at the time	on, death occurred a	t the time, date	and plac	e, and due to the	cause(s) and manner stated	
o the P vithin 2: o the F	Me	only one 3 A Co	ertifying Nurse I	Practioner: To the	best of my	knowledge	, death occurred at the	e time, date and plac	ce, and due to t	he cause	(s) and manner as	stated.	
2				M·D		00-1-7	(Type, Print) AST WEST HWY RU				29d. Date signed (Month, Day, Year)		
94		30 Name and address of	HUSAI	ipleted cause of d \mathcal{N} , $\mathcal{U}\mathcal{U}$	eath (Item	EA C	TWES T	HWY	RIVE	KOT	HE MI	20137	

State Registrar

30 Name and aboves of person who completed cause of death (Item 23a) (Type, Print)

AAD (A HUSAIN) UUOA EAST WEST HUY

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 7/2009

RWEKDALE MD 20737

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2°ear 03 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number **Funeral** (Month, Day, Year) Days Hours 212-64-3535 1 🗆 M 2 🕽 F 53 yrs Director July 4,1958 New Jersev Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director notified 1 Yes 2 K No 28a-f Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 must be 23a Funeral 2013 Harbour Gates Drive Apt. 183 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Specify: "natural", 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental I ပ Ith and Menta 27 is marked traumatic e William Sunday Stewart |Margaret Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 William Patrick Jewel/Husband 12500 Trelawn Terrace, Mitchellville, MD 20721 Important: If iten any injury or othe once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 10-8-2011 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Junera Service 2973 Solomons Island Rd., Edgewater, MD 21037 23a. 1.21. Fiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ NCREAS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No for Pregnant at time of death the 9 Unknown P.0. á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Hospital the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 within To the 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) GENSE HWY ANNAPOLY MD 21401 LateNTA 445 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) UT 3. There of Death 2. Date of Death Physician/ Month Johnston Joseph Gilbert 2:21pM 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Callaway Hospice House of St.Mary's Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 | F 12/8/1946 64 Director 577-62-0111 Washington, DC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland 힏 ral", or items 23a or 28a-f s Examiner must be notified Direct 1 🗆 Yes 2 🏝 No St. Mary's Lexington Park Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 21262 Joe Baker Court Apt.#7B 20653 USA ould be filed within 72 hours after death ond Mental Hygiene. marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Mary E. Owens Joseph S. Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49254 Demko Road, Lexington Park, MD 20653 Joseph Johnston, Jr./Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Veterans 10/19/2011 21. Signature of Funeral Service Licenson Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street, Leonardtown, MD MD 20650 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ metastate disease or condition resulting in death) colon concer Medical Due to (or as a consequence of) Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on that the death certificate be executed anding physician and use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Hospice Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) House No No ဂ္ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

, JR State

31. Date filed (Month, Day, Year) OCT 17 2011

Minal Shah, M.D.

(Check

29b. Signature and title of certifier

23415 Three Notch Road, Store2050, California, MD 20619 Registrar's Signat

Cartifying Nume Fractioner To the best of my knowledge, S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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date and place, and due to the

29d. Date signed (Month, Day, Year) 10-17-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend#23a.prt1.PerPhys.,Amend#and / Department of Health and Mental Hygiene
Registrar17.18.PerPh&Informant10-20-11Pcocr Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Catherine Jackson Month 2 0 1 10:45a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bethesda Health and Rehab Bethesda Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 💢 F Months Hours 0 ct. 26 Mississippi 020-20-8785 Director 88 1922 Usual Residence of Decedent or 28a-f show 10a, State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Bethesda 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 5721 Grosvenor Ln. 20814 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: black Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pope Edward Monroe Pope Lee Rosa Bell Lee Rosa 19a. Informant's Name/Relationship (Type, Print) daughten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zainab Abdul Kareem-1901 15th St., NW Apt#3 Wash., DC 20009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Al-Firdaus Cem. 10/6/11 Frederick, Md. Signate of Funeral Service Lice 22. Name and Address of Facility Universal Mortuary 411 Kennedy St NW Washington, DC 20011 Part 1. Enter the lifease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer's Dementia Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a sthe bunal-Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ¥ Hospital or Attending Physician: The law requires that the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 2 PNo 1 🗌 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 124 hours after death.
Funeral Director: Aft leted filled in by the fur 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Zero 1 M) 10057114 10/4/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bao Troung 5721 Grosvenor Ln. Bethesda, Md. 20814 32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 1 4 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34357 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 1934 Anita Lorraine Elizabeth Kelley-Plummer October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town or Location of Death 4c. County of Death Prince George's Fort Washington 8370 Indian Head Hwy Apt. B-17. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. 05/01/195 Director 579-86-6757 54 DC Usual Residence of Decedent than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Prince George's 1X Yes 2 No Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8370 Indian Head Hwy. Apt B-1 United States 11. Marital Status 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Black 3 Widowed 4 Divorced Specify Completed Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Federal Government Secretary marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental H 2 Charles Donnell Kelley Lorraine Elizabeth Anderson 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 83/0 Indian Head Hwy Apt B-1 Fort Washington, MD 20744 S permit. Page 1 and 2 st Department of Health a Important: If item 27 is Shawn Plummer/ Son other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mary Land
Veterans Cemetery ٥ 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 🛣 Other (Specify): Inurnment 10/14/2011 Cheltenham, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, PA M00981 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final teriosclerati Ar pertensive Itear I Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence cry: If any leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-trans and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available 24a, Was an page 2 prior to completion of cause of death? autons this certificate 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 1 28d. Describe how injury occurred 1 - Natural work? 5 Pending injury 2 🗌 No s after death Investigation Could not be Accident the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month. Day, Year)

3001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0-TO ber 11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Richard Longo, Sr. October . 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 【 M 2 🗆 F 125-38-8480 Months Hours 2/1/1949 New York 62 **Director** Usual Residence of Decedent 28a-f show 10b. County the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? ò 10e. Street and Number 10f. Zip Code Funeral items 23a USA 624 Harbor Drive 21403 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ò ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify White "natural". Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Vocational Schools 0wner 4 years other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other မ Josephine Borzellieri Nicholas James Longo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Longo/ Wife 624 Harbor Drive, Annapolis, Maryland 21403 Baltimore, 20a. Method of Disposition

1 🖸 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Westbury, New York Cemetery of the Holy Rood 10/17/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 la 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ MULTIDEGON disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, iner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or a consequence of): Exam or Attending Physician: The law requires that the death certificate be executed NEUMUR attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the atte Month Day Year Yes 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has auto-performe death? 25. Was case referred to medical completed filled in by the funeral director Certificate: To Be 26. Place of Death (Check only one) examiner. 1. Yes Other: 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, it may opinion, seasoned at the single date of the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 72199

Registrar

30. Name and address of person who

31. Date filed (Month, Day, Year)

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nondlis

completed cause of death (Item 23a) (Type, Print)

Medical

		Pleas	e Type or Prir State of Ma							_		
		1 - State Registrar			Cei	rtificate of	Death		Reg. N	0.001	L 010F	
Physicia Medic		1. Decedent's Name (First, Middle, Last) Mabell Lanham							of Death Collins 3. Twhe of Death Cober Day, 2011 2:45 PM			
Examin	er	4a. Facility Name (if not institution, gi Bradford Oaks N	,			4b. City, Town,	or Location of Deat Clinton		4	c. County of Deat Prince	George's	
Funeral Director	Г	578-40-8816	Sex 1 □ M 2 🔀 F	(In yrs. 1a	as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days			rth ay, Yeard	919 S80	thplace (State or Foreign Tth Carolina	
iryland I-f show Ted at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation	C14	nton			10d. Inside City Limits 1 ☒ Yes 2 ☐ No	
the Ma or 28a e notif	Dire	Maryland Prince 10e. Street and Number	Clinton 10f. Zip Code					Citizen of What Co				
is 23a	neral	7520 Surratts Ro	ad		20735				Ü	United	States	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 4 If If Yes, Give Year or Dates.		 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 Yes No Specify: 					14. Race - Ame Black, White Specify: B1	e, etc.	
72 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)				dent's Usual Occu kind of work done	during most of wor	rking	16b.	Kind of Business	Industry	
vithin 7 giene. er than the M		Elementary/Seconday (0-12) 6 t h	College (1-4 or 5+	⊦)	life. D	O NOT use retired Child C	,			Self-E	mployed	
be filed v lental Hyg rked othe lic event,	To Be	17. Father's Name (First, Middle, Last) Brunson Cain							(First, Middle, Maiden Surname)			
should and N is ma aumat		19a. Informant's Name/Relationship	19b. Mailing Address (Street and Number or Rural Route No.									
and 2 Health em 27 ther tr		Creola Hicks - Da 20a. Method of Disposition	10651 Crain Highway Upper									
t. Page 1 rtment of rtant: If it		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	emetery, crematory or other place) Lincoln October 2011			2011	Suitland, Maryla					
permit Depar Impor any ir once.		21. Signature of Funeral Service Lice	nsee of Ruco	ut:	70	2. Name and Addre	ess of Facility Sing Road			eral Hom	e, Inc. 20019	
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused	the death	n. Do not ente					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate Interval Between Onset and Death	
be executed sician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.									
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1							ivery Day Year		
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ending eath. or: Afte the fun	ficat	1 Natural 5 Pending 2 Accident Investigation	on	(Month, Day, Year) injury			work? M 1 \(\text{Yes} 2 \(\text{No} \) No		Edd. Beschibe new injury declared			
tal or Att irs after di al Directe led in by t	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)								(Street and Number or Rural Route Number, own, State)		
the Hospi nin 24 hou the Funer npleted fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
vith vith con S		29b. Signature and title of cartifier aurely				29c. License number D35206				29d. Date signed (Month, Day, Year) October 12, 2011		
79		30. Name and address of person who William T. Tanne	er, MD 1170	01 L	ivings	,	Fort Wa	ashingto	on, l	Md. 207	44	
Stat	е	31. Date filed (Month, Day, Year)	32. Registrar	s Signati	ure							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10,2011 Edward Warren Merson Jr. October 0 5:02 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1049 Minnetonka Road Severn Arundel Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday If Under 24 Hrs. Birthplace (State or Foreign Country) Hours 216-68-8492 Director 1 X M 2 D F 56 06/17/1955 Maryland Usual Residence of Decedent 28a-f show 10a. State the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Severn 1 Yes 2X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 1049 Minnetonka Road 21144 USA items ? permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 Divorced 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Home Improvement 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Warren Merson Sr. Ruth Corinthia Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Merson 1049 Minnetonka Road Severn,MD 21144 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Atlantic Crematory 10/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie,MD 21. Signature of Funeral Service 22. Name and Address of Facility 851 Annapolis Road Hardesty Funeral Home P.A.Gambrills,MD 21054 Oals 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ UN Canc disease or condition mos Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to in reading cause. Enter Underlying Examiner Due to (b) as a consequence of, Cause (Disease or injury that Initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death been signed by the s should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available has page 2 autopsy prior to completion of cause of death? performed 1 Yes 2 Wo within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes Division of Vital funeral director, To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No ☐ Accident filled in by the Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar

State

30. Name and address of person

31. Date filed (Mor

60

who completed cause of death (Item 23a) (Type, Print)

's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Mar	•			d Mental Hy	/gien	е		
		•	- State Registrar Amended 10	e - rm1 10/1	9/11 Cer	tificate of L	Death		Reg. N	10. 20	-	21.36
•	Physicia	n/	1. Decedent's Name (First, Middle, L.	ast)				2. Date of D)ay \	ear	3. Time of Death
	Medic			Martin				Octob		3, 20		8:10 p.m
	Examin	er	4a. Facility Name (if not institution, gi	· ·		4b. City, Town, or		eath		c. County of		
	Funeral		Hermitage @ St. 5. Social Security Number 6.		n yrs. last birthday)	Solomon If Under 1 Year	If Under 24		rth	Calver		lace (State or Foreign
	Director			1 [] M 2 X F	92 Yrs.	Months Days	Hours	Min. (Month, D 05/07	ay, Year,	9 N	Count	
	_ MC		Usual Residence of Decedent									Od. Inside City Limits
	yland -f sho ed at	양	10a. State 10b. County		0c. City, Town or Lo						10	1 🗌 Yes 2 🔀 No
	e Mar r 28a notifi	jë	Maryland St. Mary	7 S	Californi.	a 10f. Zip Code			10a (Citizen of Wh	at Count	
	ith th	ral	23309 24107 Mill Cove	Sugar Maple	Ct, Apt 8	30619				ted St		
	ems	Funeral Director	11. Marital Status	12. Was Decedent Eve	r in U.S. 13. V	Vas Decedent of H	ispanic Origin	? (Specify Yes or No		14. Race -		
9	ter de or it	by F	1 Never Married 2 Married			Yes, specify Cuba		uerto Rican, etc.)			White, e	tc.
93	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		Li fes 2 Likino	эресну.			Specify:	Whit	e
5-	72 ho	Completed	15. Decedent's (Specify only highest		(Give I	lent's Usual Occup kind of work done o O NOT use retired)	during most of	working	16b.	Kind of Busi	ness Ind	ustry
12	within giene.	S	Elementary/Seconday (0-12)	College (1-4 or 5+) 5+		sion Home		mist _	Ext	ensio	n Se	rvice
Q 2	led w Hygi other ent, t	0	17. Father's Name (First, Middle, Last		12222			Name (First, Middle	e, Maide	n Surname)		
lan	it and 2 should be filed of Health and Mental Hy, fitem 27 is marked other other traumatic event.	မ	Alexis Winfield I	Oudley Moody			Jessie	Ellen Ca	arri	ngton		
ar)	should and N is ma		19a. Informant's Name/Relationship	(Type, Print)				r Rural Route Numb				
≥,	nd 2 sealth m 27 ner tra		Carolyn L. Huff/	Friend			ve Roa	d, Califo				
Baltimore, Maryland 21215-0036	ge 1 a it of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐ Removal from State		natory`or other plac		Date	1	Location - C		
ţ	t. Pag tmen rtant: njury		4 Donation 5 Other (Spe		Charles M				_	nardt		
Bal	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature Pune al Service Lice Edward N. Brir	sfield, Jr.	I .	. Name and Addres		Brinsfiel Road, Leo	d Fu	ineral It <u>own</u> ,	Hon MD	ne, P.A. 20650
П			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused the one cause on each line.	e death. Do not ente	er the mode of dyin	g, such as car	diac or respiratory a	arrest,			Approximate Interval Between
·~~	Physician/		Immediate Cause (Final disease or condition	Atherosc	lerotic C	ardiovaso	cular I)isease				Onset and Death 15 Years
	Medical Examiner		resulting in death)	Due to (or as a c								
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of:						-	· · · · · · · · · · · · · · · · · · ·
	ed sit	Examine	cause. Enter Underlying Cause (Disease or iinjury	240 10 101 40 4 0	01100q201100 01).						1	
	xecul n and al-tra	Еха	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):							
09	ate be executed physician and the burial-transit	dical		d		_					\perp	
	ificati ng ph as th	Med	IF FEMALE:						_			
Box 687	death certificat he attending ph ed for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Fetal death 3		су			23d. Date Mont		ery Day Year
B	9 9 G	ysic	1 Yes 2 X No 9 Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	me of death 5 L	Other (specify) _		.,,		IVIOITE		Day roan
P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco	use contrib	ute to th	e cause of death?
S, F	signe d be o	Completed by						1 🗆] Yes	2 X No 3	☐ Prot	oably 4 🗆 Unknow
ord	requ been shoul	lete						24a. Wa		24b. We	ere autop	osy findings available
ec	The law cate has page 2 t	duo			<u>-</u>			aut per 1 🗆 Yes	opsy formed?	de	ath?	mpletion of cause of
al F	iician: The certificate rector, pag	Be C	25. Was case referred to medical			26. Pl	ace of Death (Check only one)	2 23	NO ₁	100	
ΖĘ	nysici nis ce direc	To E	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatier	nt 3 🗆 DOA Oth	er: 4 🗓 Nursi	ng Home 5 🗌 Res	sidence	6 Other	(Specify))
of	ing Pl		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of injury (Month, Day, Y	'ear) 28b. Time of injury	28c. Injur work	?	28d. Describe	how inj	ury occurred		
ion	ttendi death tor: A the fi	ific	2 Accident Investigat 3 Suicide 6 Could not	he	At hame form str		Yes 2 N		/C4 = 4 :	and Number	or Pural	Route Number,
Division of Vital Records,	or At after Direc in by	Certificate:	4 Homicide determine	d building, etc. (- At home, farm, stre Specify)	eet, factory, office		City or To			Or Hurar	Houte Nambel,
	To the Hospital or Attending Physician: The law requires that the within L24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying Pt	nysician: To the best of my miner: On the basis of exar	/ knowledge, death o	occured at the time	, date and pla	ce, and due to the o	ause(s)	and manner	as state	d.
	To the H within 24 To the Fi complete	Me	only one) 3 Certifying No	urse Practioner: To the be	st of my knowledge,	death occurred at th	e time, date ar	d place, and due to	the caus	e(s) and man	ner as sta	ated.
	5 N N N N N N N N N N N N N N N N N N N		29b. Signature and utile of certifier	MIRIA	^	29c. License				Date signed (
				100000	th (Itam 02-) (Time 5	D003	1563		0ct	ober	14,	ZU11
al)	U		30. Name and address of person who Charles M. Benne	·	th (Item 23a) (Type, F 145 Great		ad La	xington P	ark	MD	2065	3
IW	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	,	عدد ويس		a. K		_005	
	Registra		OCT 19	2011	J. B.	ale						

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Joseph McNamara October 2011 5:25 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home St. Mary's Charlotte Hall 6. Sex 1 X M 2 🗆 Social Security Number **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours Director 222-26-6143 67 2/20/1943 Delaware Usual Residence of Decedent show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shoraumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 Tes 2 X No Maryland St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 29449 Charlotte Hall Road 20622 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 X Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 ☐ Widowed 4 🕅 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 27 is marked John Joseph McNamara, Sr. Martha Potocki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other t Barbara Fad/Sister 25 Hutton Lane, Garnet Valley, PA 19060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 ី Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-EcholsCrem; 10/17/2011|Charlotte Hall, MD Signature of Funeral Service Lines 22. Name and Address of FacilityBrinsfield-Echols F.H., P.A. MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final set and Bea Physician/ disease or condition resulting in death) - bu Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami de th certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of): burialttending physician or use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an To the Hospital or Attending Physician: The law this certificate has autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Assissted Liver ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours after To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

Registrar

29b. Signature and title of certifi

Amir Alikhani,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2 0 2011

101

Centennial

46046

Suite B, LaPlata, MD 20646

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 23a,28f per me,g923,01/12/2012dhb
State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item 28f per me,g920,10/27/2011dhb
Reg. No. 2 | | Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** October 18, 2011 0725 Ann Marie Magruder /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick College View Center Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ X Months Days Hours Min 79 Director Oct 21, 1931 217-28-5169 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 225 Frock Dr. 21157 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ **3** Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4.2 should be filed w h and Mental Hygier 7 is marked other th 12 Custodial Black and Decker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Aertal Important: If then 27 is marked oth any injury or other traumants. Charles Key Martha Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Jones/Nephew 11107 Willow Button Rd. Columbia, MD 21044 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westminster Cemetery 10/24/2011 | Westminster, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Factoritts Funeral Home & Chapel, PA K G 412 Washington Rd. Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Approved ND DIME **Physician** Sevene Pylmanary /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Dav P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Atrial tibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Anemia, Hip Fracture 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed Vital **4** Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Tursing Home 5 Residence 6 Other (Specify) Certification: To Yes 2 No Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Leff LVP 5 ☐ Pending investigation 1 Natural 10-10-2011 Unknown 1 ☐ Yes 2 ☑ No Fracture from Accidental full death Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide cut home 225 Frock Drive, Westminster,MD 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-20-2011 060417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702 Hemen shah 65 Thomas Tohnson C 31. Date filed (Month, Day, Year) State OCT 27 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Genevieve M. Nelson 10-13-2011 20:30 PM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick 321 North Maple Avenue Brunswick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-25-1918 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 💢 F 93 Maruland 213-20-6163 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Brunswick 1 X Yes 2 □ No Frederick Maruland 10g, Citizen of What Country? 10e. Street and Number 10f. Zin Code UnitedStates of America 21716 321 North Maple Avenue 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕱 No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Family 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ann Ryan Charles Walter Brinkman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Revolution St, Apt 508, Havre de Grace, Maryland Carol Brewer (daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 10-14-2011 WestChester, Pennsylvania RA Ferris&CoInc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 |123 S. Washington St., Havre de Grace, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) -Unnestive Due to (or as a nsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Due to (pras a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Ye ar Month Day Pregnant at time of death 5 Other (specify) 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **No** 1 ☐ Yes 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, page certificate director, After this funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital 5

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/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event

Physician

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signed by the a

P.O. Box 68760,

Examiner

Physician/Medical

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Be Completed

Medical Certification: To

29b. Signature and title of certifier

Christopher

31. Date filed (Month, Day (Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

emin 732. Registrar's Signature

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

610

29c. License number

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ ľð, 2011 19:30 м Robert Earlester Nelson, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F March Day Ye Days Country) Hours Months 69 DC 577-54-3539 Director Usual Residence of Decedent shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland Director 1 XYes 2 No Brentwood Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20722 United States 4142 Bunker Hill Road Apt. 214 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry ntal Hygiene. ed other than " event, the Mer Elementary/Seconday (0-12) 12th College (1-4 or 5+) Government Driver Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Robert Earlester Nelson Sr. Gloria Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) 9104 Sherwood Forest Way Upper Marlboro, Md. Hope Gray - Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date demetery, crematory or other place)
Mary Land Veterans
Cemetery October 18. 1 Burial 2 Cremation 3 Removal from State 2011 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licensee 0 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No q 🗌 Unknown page 2 should be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 Yes 2 No 2 Yes 25. Was case referred to medica funeral director. 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: s after death. 1- Natural iniurv 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060100 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 7 yminn AGMED Sars Date filed (Month, Day, re 31 University 3400 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per Maryland Department of Health and Mental Hygiene 2 34366 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nicklas 2011 2:18 P M Mabe1 May October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 6788 Keller Lime Plant Road Buckeystown 5. Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Mary Land 1 M 2 DXF October 15. 1927 216-22-9433 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location with the Maryland Director notified 1 Yes 2 X No Buckeystown MD Frederick 10f. Zip Code 10g. Citizen of What Country? ŏ 10e. Street and Numbe must be 23a United States 21717 6788 Keller Lime Plant Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Ro Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) al Hygiene, life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Postal Clerk Postal Service Ith and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mabel Lorraine Barnes မ Charles May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heatth ar Important: If item 27 is any injury or other trau 6788 Keller Lime Plant Rd, POB 116, Buckeystown, MD 21717 Roger Nicklas/ Husband altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory 10/27/11 Smithsburg 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home Signature of Funeral Service Licensee Church St. Frederick, MD 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death dvanc Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 menths? Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate has death? 2. completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ၀ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury 1. Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ModtCal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) O Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year,

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32. Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates.			No No		1 🗆 Yes	1 ☐ Yes 2 🛣 No Specify:					Specify: White		
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Medical Examiner		resulting in death)	ſ	Due to (or as	a consequ	ence of):	_								
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco										use contribute to the cause of death?			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 230 9 Joseph A. Pamepi

4a. Facility Name (if not institution, give street and number) Medical 4c. County of Death Examiner 4b. City, Town, or Location of Death Cumberland Alleg WMHS Regional Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday Country 1 ₹ M 2 □ F Months (Month Day, 1 Year) 27 234-40-3360 84 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mehtal Hygiene.
Important if item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allea Luke 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 241 Fairview St 21540 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

XYes 2 \(\sum \) No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 ▼ No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work do ne during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Barber Barber Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Pietro Pamepinto Virginia Caldron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Pamepinto Box 89CC New Creek, Son 72 WV 26743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Peter's Cem 10-7-11 4 ☐ Donation 5 ☐ Other (Specify) Saint Westernport, MD 22. Name and Address of Facility Fredlock Funeral Home 21. Signature of Funeral Service Licens Man H. Fredle Jones St. Piedmont, WV. 26750 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Due to (or is a consequence of): Ph sician/ disease or condition resulting in death) day Medical Examiner 1 day neumonia Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End stage lenal disease 1 Yes 2 No 3 Probably 4 Unknown has been Tacky - Brady Syndrma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? congestive Heart Failure (systolic dysfunch m this certificate Yes 2 N 2 No 1 🗌 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 No ၉ 1 Propatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident 24 hours after death Funeral Director: Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 To the Vithin 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 10-4-11

SETON DR. CUMBERLAND, MD 21562

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ENDNI

30. Name and address of person who completed cluse of death (Item 23a) (Type, Print)

ChRISTOPHER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34369 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2011 ear 7:00 a.mM Da1y October 0 Mary Pappaconstantinou Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's St. Mary's Callaway If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 □ M 2 🔯 F Days Hours Months 05/02/1943 Massachusetts Director 025-32-5842 68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 Yes 2 X No Waldorf Maryland Charles ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a United States 3473 Forest Glenn Court 20601 death \ Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. þ ō 1 Never Married 2 X Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. If Yes Give "natural", Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Education 5+ Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even မ Harriett T. Clark John Daly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allan Lane, Mechanicsville, MD <u> Charles Pappaconst</u>antinou/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Cem 10/18/2011 Leonardtown, Memorial Centify Brinsfield Funeral Home, P.A

Toppardtown, MD 20650 Margaret H. Hicks 22955 Hollywood Road, Leonardtown, MD M01631 Hicks 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-t physician s the burial Physician/Medical requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) signed by the a g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes funeral director, page 2 should peen 24b. Were autopsy findings available 24a. Was an this certificate has autopsy prior to completion of cause of death? 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No ပ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specification of the control of the c 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? thin 24 hours after death.

the Funeral Director: After impleted filled in by the funeral Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 No M 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Fune completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of on who completed cause of death (Item 23a) (Type, Print) 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650 Jennifer D.0 Chmidt,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | 34370 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Owens Reynolds October 201 Tal 6:00 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4743 Old Morgantown Rd., West Friendsville Garrett 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Days Min. Hours ^{Yea}1917 Octonth, 27, Director Pennsylvania 174-03-5121 93 Yrs. Usual Residence of Decedent show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 X No MD Garrett Friendsville ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 4743 Old Morgantown Rd., West 21531 USA items ? death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give ō ģ 1 Never Married 2 M Married 3altimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Ser than "r 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Repair Foreman Steel Mill Be 17. Father's Name (First, Middle, Last) should be file and Mental h 18. Mother's Name (First, Middle, Maiden Sumame) ည William Hampton Reynolds Cordelia Owens other traumatic permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21531 Mildred E. Reynolds/Wife 4743 Old Morgantown Rd., West, Friendsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Rose Hill Cemetery Oct. 11, 2011 Butler, PA 4 ☐ Donation 5 ☐ Other (Specify) Signal of Foneral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, Vsur Lurage P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) ONGESTIVE Medical Due to (or as a consequence of): Examiner 1ears SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Examir transit. Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) -burialng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Por Pregnant at time of death Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death?

1 Yes 2 No autopsy performed this certificate Yes 2 Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Matural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST State Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 2011 Hiltrud Rooney 2:09 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 805 Coxswain Way #209 Annapolis Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Germany 1 M 2 XF Days Director 5/22/1942 Yrs 219-48-8607 69 Usual Residence of Decedent show 10a. State 72 hours after death with the Maryland Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 Yes 2 X No MD Anne Arundel Annapolis 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 805 Coxswain Way #209 21401 USA items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? or Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 marked other than "natural". If Yes, Give Year or Dates 1 Yes 2 X No Specify 3 XWidowed 4 Divorced Specify: White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 7? It and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>0</u> Stefan Sedlacek Wilhelmine Heister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is Peter S. Harris / Son 112 North Pointe Terrace, Middletown, MD 21769 permit. Page 1 and 2 Department of Healti Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 9 1 Burial 2 X Cremation Removal from State injury (4 Donation 5 Dother (Specify Kalas Crematory 10/11/2011 Edgewater, MD Sign tur of Fine al Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician. Onset and Death Lance disease or condition UNG Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Dim to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 2 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2. No Other: ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 24 hours after death.

Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending injury Investigation 6 Could not be 1 Yes 2 No Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Cectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a License number 29d. Date signed (Month, Day, Year) 10/10/1 MO

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address

31. Date filed (Month.

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env Scile 200 Arapio Mo 21401

who completed cause of death (Item 23a) (Type, Print)

jistrar's Signature

2003

1 2 2011

Please Type or Print in Black indelible loke Ensure All Repries Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 201^vfa Thelma L. Shoemaker 11:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Grantsville Goodwill Mennonite Home Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🕱 F Hours 88 May 12, Year 1923 Pennsylvania Director 219-14-6330 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No PA Somerset Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15562 USA 143 Shoemaker Hill Rd. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🗶 No Specify: Specify: White "natural" 3 X Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nettie Livengood Homer Rembold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15562 127 Shoemaker Hill Rd., Springs, PA David Eugene Shoemaker/Son Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 6, 2011 Springs, PA Springs Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Home, Inc. P.O. Box 116, Salisbury, PA 23a. Part 1. Exterithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for i Month Dav Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗆 Yes 2 🗆 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Arvetta 8:50 PM arrie 0 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Oakland Nursing and Rehab Oakland garrett 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1□ M 2 12 F Months Days Hours Min 220-74-3809 **Director** 81 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

'is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination must be a cofficial at Director 1 □Yes 2√2 No MD Garrett Friendsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 326 Noah Frazee Road 21531 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ş 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ James Fearer Dessie Schroyer Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health a if item 27 is or other tr 326 Noah Frazee RD., Friendsville,MD 21531 John H. Sines/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sand Spring Cem. 10/11/11 Friendsville, MD 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that course the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 1=on 1=1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) P.O. I signed by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

311 N. Fourth St. Suite 1 Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Kenneth Buczynski

OCT 11 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont 10/6/2011 Physician/ James William Thomas 2154 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Country) 471871935 218-34-7219 MD Director 76 Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No MD Lothian Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20711 USA 5339 Greenock Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces? Black White etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 In and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Farming Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elsie Elben Samuel Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 5349 Greenock Rd. Lothian, MD 20711 Rebekah Lare 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Atlantic Crematory 10/13/2011 Glen Burnie, MD 4 Donation 5 Other (Specify Signature of Euperal Service Li 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Difficile Colitis Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the as IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law r 24 hours after death.
Funeral Director. After this certificate has be felled filled in by the funeral director, page 2 s autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's 1 Yes 2 No ၉ 1 Natient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I complet 3 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number 10/12/11 D46052 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2003 Medical Parhway annapolos HD verd Berl egistrar's Signature State

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc g921 11-21-11 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TAYLOR ELLEN JOSEPHINE OCTOBER 2011 9:03A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST. MARY'S ST. MARY'S HOSPICE HOUSE CALLAWAY 9. Birthplace (State or Foreign Couptry) W • VIRGINIA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Months Hours Min ocT.23 1 □ M 2 🔀 F , 1º941 69 W. 234-64-1167 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes XXNo LA PLATA MD CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20646 U.S.A. 9010 BRIDGETT LANE death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 3 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) CUSTOMER SERVICE SAFEWAY FOOD STORES Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည KATHRYN MARIE VANCE FRAZIER T. BOYD 1 and 2 should b of Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA QUALTERS/DAUGHTER 9010 BRIDGETT LANE LA PLATA, MARYLAND 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W.A.BOYD CEMETERY 27, 2011 GRUNDY, VA 22. Name and Address of Facility RAYMOND FUNL. SERVICE, 21. Signature of Funeral Service L tout soe 20646 M00641 5635 WASHINGTON AVE., LA PLATA, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or linjury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending | IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Day Pregnant at time of death been signed k should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 has prior to completion of cause of death? this certificate 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Spec within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral! 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred couse Certificate: or Attending (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide
Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) H0055751 10-21-11 Leonardtown ho completed cause of death (Item 23a) (Type, Print) Merchants LN Suite 205 20650 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Unkle, Sr. ĬŸ, Henry 2011 October | 9:37 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 37300 New Market Turner Road Charlotte Hall Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Days Hours Country) Director 214-32-9442 80 02/08/1931 Maryland Usual Residence of Decedent 28a-f shov Ħ 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 ☐ Yes 2 🗷 No Maryland St. Mary's Charlotte Hall the 10e, Street and Number ò 10g. Citizen of What Country? Funeral 23a 37300 New Market Turner Road 20622 USA items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ö δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) the 7 Furniture Restorer Furniture Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Menu. ည James Unkle Pear1 Marie Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sł tment of Health a tant: If item 27 i Daniel B. Unkle/Son 29485 Whalen Rd., Charlotte Hall, MD 20622 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 5 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Charles Memorial Grd. 10/24/2011 Leonardtown, MD 22. Name and Address of Facility Mattingley—Gardiner Funeral Home, 41590 Fenwick St., Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardio Respiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit requires that the death certificate be executed Diabetes Mellitus Exar that initiated events physician ars the burial-t resulting in death) Last Due to (or as a consequence of) Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 ed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Month Year Pregnant at time of death 9 Unknown 9 Unknown signed by d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b History of Cerebrovascular Accident 2 No Completed 1 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy page 2 perform 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury 1 Yes 24 hours after death. Funeral Director: A 2 No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 3 L only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) P 0006- 20 2011 009178 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Youngsik Moon, M.D. 24435 Mervell Dean Rd., Hollywood, MD 20636

DHMH 17 Rev 7/2009

State Registrar egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Harry Frederick Warnick Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Health Center Cumberland 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** (Month, Day, Year) Country) Months Days Hours Director 219-14-5119 89 09 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Garrett Bloomington 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 23 Warnick Avenue 21523 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1843 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 12 barber <u>barber shop</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter P. Warnick Elizabeth Foreman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris J. Zais-daughter 23 Warnick Ave, Bloomington, MD 21523 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Philos Cemetert 10/7/2011 Westernport, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home PA 21. Signature of Funeral Service Licens N 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrowascular accident Pnysician/ day disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? atrial hor llation 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of gastraintestral bleeding 24a. Was an autopsy performed? 1+4pertersion 1 Yes 2 No 25. Was ca e referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 10-4-11 D0059987 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher S. Vagnoni, MD, 925 Seton Drive, Cumberland, MD 21502

Registrar

11-07407 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gage T. Welch State of Maryland / Department of Health and Mental Hygiene 2011 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 26, 2011 Medical Examiner Gage Thomas Welch 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital **Erederick Frederick** 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Days Months Hours Director 213-19-0121 1 M 2 F 02 02 1988 Usual Residence of Decedent 10b. County 10c. City. Town or Location 23a or 28a-f show notified at once. 28a-f show Frederick Frederick and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 Split Rail Ln USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If item 27 is marked other than "natural", or items? Armed Forces If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. Yes 3 Widowed If Yes, Give Yee 4 Divorced 1 Yes 2 No specify: Specify. 2 or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 1andscaper landscaping of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Gary B. Welch Lisa Prouty ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WD: William Welch-grandfather 491 Oakland Drive, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify L Davis Crematory 9/28/2011 Smithsburg, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility David A. Burdock Funeral Home PA 21 N 2nd St, Oakland, MD 21550 Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line /Medical a. Benzodiazepine Intoxication and Cocaine and Opiate Use Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED attending physician for use as the burial AMENDED 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available certificate has b ector, page 2 sh prior to completion of cause of performed death? Yes 2 V No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient Other4 this ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 Yes 2 After t 28a. Date of Injury (Month, Day, Year) Sep 18, 2011 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification 1 Natural 0600 hrs Pending 1 Yes 2 ✔ No 2 Accident Investigation

34378

3. Time of Death

1440 hrs

MD

10d Inside City Limits 1 Yes 2 No

Approximate Interval

Between Onset and

Death

Year

2 No

Day

White

Division of Vital Records, P.O. Box 68760,

28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 1316 Split Rail Lane, Frederick, MD determined (Specify) At home Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Wedlcal Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 3, 2011

900 W. Baltimore Street, Baltimore, MD 21223

OCME

Deputy Chief Medical Examiner 31. Date filed (Moi State **OCT 0** 6 2011

Mary G. Kipple MD.

30. Name and add

32. Registrar's Signature

ss of person who completed cause of death (Item 23a)

ORIGINAL

Registra

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month RD 1352 M OHN ľÖ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min 1 **Z**M 2 □ F Director 023-28-5736 73 07/12/1938 MASSACHUSETTS Usual Residence of Dece or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Numbe 10f. Zip Code 0 10g. Citizen of What Country? pe items 23a Funeral 2590 TWIN LANDING COVE USA 21401 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give 0. Black, White, etc. þ 1 Never Married 2X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural" Completed 3 Widowed 4 Divorced Specify: Year or Dates WHITE traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 AUTOMOBILE INSURANCE APPRAISER AUTOMOBILE INSURANCE other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ပ္ JOHN J. WARD SR. MARY M. SULLIVAN and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 DONNA M. WARD/WIFE 2590 TWIN LANDING COVE. ANNAPOLIS, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. ō cemetery, crematory or other place)
ESAPEAKE CREMATION 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/13/2011 STEVENSVILLE, Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line nset and Death Immediate Cause (Final (Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? Yes 2 No death? 2 No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: ٩ 1- Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce pleted cause of death (Item 23a) (Type, Print) Name and address of pers 447 DEFENSE HWY A NNAPOLIS MOLITUI TA EN HAER State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Month 10 Physician/ Williams Day 07 cosemary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Mandrin Hospice House Harwood Anne Arundel . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 K 0972271920 New York Director 066-12-0394 91 Usual Residence of Decedent r 28a-f shorn notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Anne Arundel 1 Yes 2 X No Odenton 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 8730 Aspen Grove Court 21113 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ρ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M College (1-4 or 5+) Department Manager Retail 04 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Riordan Bertha Onetto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Williams 8730 Aspen Grove Court Odenton,MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Atlantic Crematory 10/10/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pun service License 22. Name and Address of Facility 851 Annapolis Road Gambrills,MD 21054 Dan Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Physician/ reast cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Year Month Pregnant at time of death Day 1 ☐ Yes 2 ₽ 9 ☐ Unknown detached Unknown n signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 3 Probably 4 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been significated by the funeral director, page 2 should the prompleted filled in by the funeral director, page 2 should the page 2 should the page 2 should be applied to the page 3 should be applied to the applied to the page 3 should be appli ensio 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? performed Yes 2 No 1 Yes 2 000 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 (**)**KN0 မ 1 🗌 Yes hoppice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opiniori, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 1106 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ense Ifay

State Registrar istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year EATRIC BOTOBE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 103PITAL HESTE ERTOWN If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min. 1 🗆 M 2 🕱 F 12/29/1926 VIRGINIA Director Yrs. 230-28-8155 84 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MD KENT CHESTERTOWN ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 10826 FORESTON ROAD 21620 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ould be filed within 72 hours after dong Mental Hygiene.

marked other than "natural", or i 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 BOOKKEEPER LIBRARY OF CONGRESS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN JESSE ROBINSON MOLLIE MARCUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a LOLA MARIE BROCKMAN / DAUGHTER 10826 FORESTON ROAD CHESTERTOWN, MARYLAND 21620 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ANSON MEMORIAL PARK 10/11/2011 WADESBORO, NC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on the use on each line. Approximate shock, or heart failure. List only or Interval Between Immediate Cause (Final Onset and Death MYOCARS, AL ACUTE Physician/ INTARCTON disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner (U) 957WE FAIURZ Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or Cause (Disease or iinjury that initiated events and tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Dav Year Pregnant at time of death 1 Yes 2-2 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy this certificate 2-1 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ည 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death e Hospital or Attending Pt 124 hours after death. e Funeral Director; After the leted filled in by the funeral 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D completed filled is Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie D0071130 2011 5

DHMH 17 Rev 7/2009

State Registrar KERI

31. Date filed (Month, Day,

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Brown

CHESTERIOUN

21620

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

14C035

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34382 State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2011 JACKSIE ADELAIDE WILLIAMS oCT.20 10:58A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ABBEY MANOR ASST. LIVING CHARLES LA PLATA 9. Birthplace (State or Foreign TX7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Director 456-16-0252 97 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD. CHARLES LA PLATA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 123 MORRIS DRIVE U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file, and Mental H is marked of Department of Health and Menta Important: If item 27 is marked any injury or other transconce. ပ JACOB OCELOA PECK MINNIE BELLE WHITLOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAYLENE DIXON-DAUGHTER 407 S.W. COURT LUSBY, MD. 20657 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State METROPOLITAN 4 Donation 5 Other (Specify) CREMATORY 10-22-2011 ALEX., VA. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SERVICE, P.A. Approximate Interval Between Onset and Death Immediate Cause (Final Seni Physician/ disease or condition resulting in death) / Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 Dunknown detached g Unknown s been signed by i should be detack Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Tyes 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 32. Registrar Signature 31. Date filed (Month, Day, Year) State 7 2011

Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 8^{Day} Physician/ OCTOBER 2011^{Year} CLIFFORD CASH YOUNGBLOOD 10:43 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🔀 M 2 🗆 F Days 086-14-5176 Hours 1172371921 New York Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1x Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5656 Crabapple Ct. 21703 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. er than "natural", or the Medical Examin by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ANo Specify: SpecifWhite 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) roads supervisor county gov't. traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred C. Youngblood Sr. Ada J. Crawford 19a. Informant's Name/Relationship (Type, Print)
Clifford Youngblood Jr. (Sqn) 104 Larch Lane, Middletown, MD 21769 permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is n 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Smithsburg Crematory of Other place)

Smithsburg Crematory 10/9/2011 Smithsburg, MD Cremation 3

Removal from State 1 🗌 Burial 5 ☐ Other (Specify) 4 Donatio ure of 2Doma1ddreBo Faqthompson Funeral Home POB 18, Midddletown, MD 21769 Part 1. Enter the disease, or compli bock, or beart failure. List only one hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e, or complicati Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examiner that the death certificate be executed neumonia and that initiated events resulting in death) Last Due to (or as a consequence the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: . nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
 5 Other (specify) Month Pregnant at time of death Dav Linknown 9 Unknown þ signed t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 741 To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform certificate Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ M6 Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 No s after death. Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) upleted filled in by 4 Homicide determined within 24 hours a

To the Funeral I.

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 65183

State Registrar Frederick, mo alloi

WITHST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ina

400

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (* not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSDHO 12 8. Date of Birth 6. Sex Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** (Month, Day,) AUG. 26 ^(ear)952 250-94-9412 SOUTH CAROLINA Director 1 □ M 2 🏲 F 59 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified PRINCE GEORGE'S BOWIE 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3010 AMPLE COURT 20716 Page 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: BLACK "natural" 3 Widowed 4 Divorced Completed al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GOVERNMENT IT TECH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked ot r other traumatic ever မ MAMMIE IRVIN LAWYER THOMPSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3010 AMPLE COURT BOWIE, MARYLAND 20716 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau RICHARD STRONG/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State RIVERDALE, MARYLAND 10-25-2011 RIVERDALE CREMATORY 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS Signature of Funeral Service Licensee FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or rearrifail re. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Rendl cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.
Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Unknown 1 Yes 2 No 3 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 X No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and 29d. Date signed (Month, Day, Year) 29c. License number who completed cause of death (Item 23a) (Type, Print)

Registrar

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Registrar's Signature

Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October WN 0917 A M)00K 2011 Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death **Examiner** 4c. County of Death ross t HOSPITOU PrINCY Montgomer 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Country) Director 1 □ M 2 🗹 F Korea or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Nev 1 Yes 2 No MONTGOMERV 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify ASIAN If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DOWOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) housewife College (1-4 or 5+) DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NOOC 500 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter Olney, MD Important: If item 27 any injury or other tra Queen Elizabeth Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State Olney, Maryland remotory 10-30-2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ucensee 22. Name and Address of Facility HOWL Howell 10220 Guittord Koaci 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as that the death certificate be executed the burial-transit Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 signed by the attending plug be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 No 2 🗆 No 1 🗌 Yes Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D 66249 10-26-201 and address of person who completed cause of death (Item 23a) (Type, Print) Glen Road Silver Spring, MD onathan Wan 1500 FOREST 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Anderson 7-28 PM Agaither Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore St. Agnes Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 05-20-42 Country) 69 215-40-3886 MD **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director 1 Yes 2 No Baltimore Catonsville MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 706 Lenstrom Friend Court 21228 USA 14. Race - American Indian, Black, White, etcAfrican Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates Specify: American 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other transment. College (1-4 or 5+) Elementary/Seconday (0-12) 12th Grade Mercy Medical Ctn. Geriatric Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mae Carter Mack Gee Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Lenstrom Friend Court Catonsville, MD. Marion Tucker-Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11-01-11 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Pnysician/ bookbrasy disease or condition resulting in death) 1 VIDOUR Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 ası 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) signed by the a a
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an CVA autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident injury 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Medic Resider 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

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caton ave, Baltimore

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2011 5:00 A. M October 26, William Clifford Adkins Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Manchester Longview Nursing Home 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea **Funeral** Months Days Hours 1**X** M 2 □ F 1917 93 1. 217-05-0626 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 USA 23a (21074 19100 St. Abrahams Court Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 1 Never Married 2 Married 1 ∐Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) than " College (1-4or 5+) Elementary/Secondary (0-12) Aircraft Mechanic Airport 12 12 should be filed w h and Mental Hygiel 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Roxie Carver William Clifford Adkins Sr. Pages 1 and 2 should ! nent of Health and Men ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19100 St. Abrahams Court, Hampstead, Maryland 21074 permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau Leah B. Ewell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 10/29/2011 Bel Air, Maryland 21. Signatur Wuneral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reavy **Physician** Metastatic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? ned by the atter e detached for u Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 48 Nursing Home 5 Residence 6 Other (Specify) 2 13 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To s after death. 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury 1. Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Hospital or A 24 hours after e Funeral Dire 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 37473 10/00/etable 26,2011 use of death (Item 23a) (Type, Print) 30. Name and address of person who complete Ave Nodis

State

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death OCTOBER 25,2011 Physician/ 00:15A DOUGLAS **MCARTHUR** ADKINS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD UPPER CHESAPEAKE MEDICAL BELAIR If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Funeral Months MARCH Day, WEST VIRGINIA 1**X** M 2 □ F 233-60-4586 3,1942 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at Director 1 🗆 Yes 2 🔀 No **EDGEWOOD** HARFORD MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral USA 223 KENNARD AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) A.P.G. SUPERVISOR Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ NORA FOWLER LONNIE ADKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 70 MULE DEER COURT ELKTON, MD. 21921 DTR. REBECCA DITMORE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 10/25/01 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-29-2011 WEST VIRGINIA CYRUS CEMETERY 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 21. Signatur of Fulleral Service Licensee BELAIR, MD. 21014 610 W. MACPHAIL ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Approximate Interval Between Ph_sician/ ITE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown STREPTOCOCCAL Completed 24b. Were autopsy findings available prior to completion of cause of death? MULTISYSTEM ORGAN FAILURE 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No To the Hospiral or Attending Physician: The within 24 hou s after death

To the Funeral Director: After this certificate I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier (Check 29b. Signature and title of certifier 25 2011 were gury 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UPPER CHESAPEAKE LTEALTH BELAIR MARYLAND 10 V ATRICIA GURNY 31. Date filed (Month, Day, Year)

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 26^{Pay} 2011^{ar} Physician/ October 12:18 A M Marcus Garvey Battle Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Howard Columbia Gilchrist Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Social Security Number **Funeral** Months Davs Hours 1 🛣 M 2 🗆 F July 28, 1924 New Jersey 100-22-4152 87 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location at 10a. State 10b. County filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Yes 2XX No Columbia Howard Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral U.S.A. 21044 5169 Harpers Farm Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. ıral", or iter I Examiner ı Armed Forces? þ 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: **Black** "natural", Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) 3.2 should be filed within 72 lath and Mental Hygiene.
27 is marked other than "r traumatic event, the Med ocial Work Administrator and Elementary/Seconday (0-12) College (1-4 or 5+) Non-Profit and Education Educator 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Noble ျ Edward Battle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Columbia, Maryland 21044 5169 Harpers Farm Road permit. Page 1 and 2 s Department of Health Evelyn Kays-Battle (Wife) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, Maryland 11-7-2011 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee Columbia, Maryland 21045 MO1234 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAR DIO MYOFATH Due to (or as a consequend of): Physician/ disease or condition resulting in death) Medical Examiner MYDCARDIAL

Due to (* as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine CORONARY attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? Month 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, STROKE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DIABETES 24a. Was an has e 2 s page KIDNEY DISEASE certificate CHRONIC 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number **D64395** 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi OCTOBER 26, 2011

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month

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egistrar's Signature

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CEAAR LANE

COLUMBIA, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN, MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year 1842 M Physician/ THOMAS BROUSSARD 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Howard County General Hospital Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. 1 🗶 M 2 🗆 F January 22,1932 213-30-3254 Louisiana Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Elkridge Maryland Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21075 5741 Old Landing Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Ammed Forces: 1 XXYes 2 ☐ No 1 Never Married 2 K Married þ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

The 17 is marked other than "natural", or only or other traumatic event, the Medical Examilury or other traumatic event, the Medical Examilury. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) D.C.A. Food Industry Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pearl Manville Wallace Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elkridge, Maryland 21075 5820 Timberview Drive Pamela Webster (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Eurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or Ellicott City, Maryland Good Shepherd Cemetery 10-31-2011 4 Donation 5 Other (Specify) Funeral Service Licensee 21. Signature 22. Name and Address of Facility Witzke Funeral Homes, Inc Columbia, Maryland 21045 5555 Twin Knolls Road 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLERDTIC Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail acc.

Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certificate: To 1 Inpatient 2 FR/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after deal To the Funeral Director: Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature an title of certifier 29d. Date signed (Month, Day, Year) Oct

State Registrar

DHMH 17 Rev 7/2009

ane Columbia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

26

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 3439 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2011 **JAMES** PHILIP 1:50A M **BROADY** Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCREST HOSPICE HOWARD COLUMBIA Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months (Month, Day, Ye APRIL 30 **Director** WASHINGTON, DC 577-30-9421 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11054 GAITHER FARM ROAD 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No ARMY
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Hygiene. other than "natural", 1 ☐ Yes 2 X No Specify: SpeciAFRICAN AMERICAN Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed withi f Health and Mental Hygien item 27 is marked other th 5+ EXECUTIVE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည JAMES THOMAS BROADY EVA MAE HUTCHINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 19a. Informant's Name/Relationship (Type, Print) BARBARA ALINE BROADY/WIFE 11054 GAITHER FARM ROAD ELLICOTT CITY, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARLINGTON CEMETERY 1/23/2012 ARLINGTON, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. En et the disea of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ END STAGE RENAL disease or condition MONTHS Medical resulting in death) Examiner CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, Exami sician and burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown in the past 12 months?

1 Yes 2 No Day Yea Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, KENAL CELL CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown YASTRITIS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No Hospital or Attending Physician: of Vital completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 🔀 Natural iniurv 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital within 24 hours a To the Funeral I

State Registrar 29b. Signature and title of certifier

6336 LEDAR LANE COLLEMBIA, MD 21044 DANIEUE DOBERMAN, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D64395

29d. Date signed (Month, Day, Year)

OCTOBER 21,2011

11-07845 Jos

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Joshua Ball		- For State	State	of Maryla		epartme Certifica			d Ment	al Hy		eg. No. 20		34392
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First JOSHUA	Middle,Las	st)	BAL	L					Date of Dea Month October 1	ith		3. Time of Death 2232 hrs
,		4a. Facility Name (if not in N/B I 495 N of Rt		e street and nu	imber)			City, Town, or _anham	Location of			4c. County of Prince Go		
Funeral Director		5. Social Security Number 579-15-0222	6. S	ex Xm 2∏F	7. Age (In)	yrs. last birth	nday) Yrs.	If Under 1 Year Months Days		24Hrs. Min.		rth(MM/DD/YYYY) 1988	g. Birt Foreig Cor	n WASHINGTON
, any		Usual Residence of Deced 10a. State 10b. C	ent			City, Town	or Location							10d. Inside City Limits
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number		GEORGE'	S	BOWII		0f. Zip Code			1	0g. Citizen of Wha	it Cour	1 X Yes 2 No
h with the l ems 23a or be notifie	L	2912 TERRAG		12. Was Dec		in U.S.		2071 Decedent of His specify Cuban	panic Origi			USA - 14. Race - White,		can Indian, Black,
s after deat	⋧┞	1 Never Married 2 3 Widowed 4	Divorced	1 Yes If Yes, Give Yea or Dates:	2 🗓 1		1 Y	es 2 No	specify:			Specify:	BLA	
2 hour	Completed	15. Decedent's Education Elementary/Secondary (College (1	•	<u> </u>	luring most	Usual Occupat of working life.	DO NOT L			16b. Kind of Bus		ndustry
21215-0036 July be filed within 7 Mental Hygiene. marked other than cerent, the Medita	Be Con	17. Father's Name (First, N LEWIS ROGE									First, Middle, I	Maiden Surname)		
MD 21;	٦	19a. Informant's Name/Rel BETTY WHIT				29	912 T	ERRAGON	LANE	per or Ru BOW	ral Route Num VIE, MA	nber, City or Town RYLAND 2	State 071	Zip Code) 5
Baltimore, oemit. Pages 1 and Department of Heal Important: If iten injury or other tra		20a. Method of Disposition 1 Burial 2 X Cre 4 Donation 5 Ott			om State	cremato	ry or other	n (Name of cen place) CREMATO			Date 19-11	20c. Location - 6		Town, S tate MARYLAND
Balti permit. Departm Importa		21. Signature of Funeral S			lls			ne and Address 4 LANDC						L HOME, INC. AND 20785
Physician /Medical =xaminer		23a. Part I. Enter the disea failure. List only one Immediate Cause (Final di	ause on ea sease a.	ach line. Multiple Inju	uries		t enter the	mode of dying,	such as ca	rdiac or r	espiratory arr	est, shock, or hear	t	Approximate Interval Between Onset and Death
		or condition resulting in de Sequentially list conditions if any, leading to immediat	b.	Due to (or as a		·								
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be execu ician and	dical	UNPENDED	d.	AMENDED										
6876 certificate nding phy	cian	F FEMALE: 3b. Was decedent pregnal past 12 months? 1 Yes 2 No 9			irth ant at time	2		death 3 [Ectopic	pregnand	су	23d. Date of d Month		ay Year
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Division of Vital Records, P.O. Box is or Attending Physician: The law requires that the death is after death. al Director: After this certificate has been signed by the attered by the funeral director, page 2 should be detached for upon the control of the con	Completed										24a. Was autop perfo	osy pr rmed? de		topsy findings available ompletion of cause of
ital Redicion: The s certificate rirector, page	8	25. Was case referred to mexaminer?	Ī	Hospital:	npatient 2	ER/Ou	tpatient 3		of Death (0			Residence 6	Other	Scene
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	tion: To	1 Yes 2 N 27. Manner of Death 1 Natural 5	Pending	28a. Date Oct 18,	of Injury		ime of Inju	ry 28c. Injur	yatWork? ′es 2 ✔ I	S S	8d. Describe I	how injury occurre	<u></u>	n into disabled
Division ospital or Attend hours after death, uneral Director: y filled in by the f	Certification:	2 Accident 3 Suicide 6 Homicide	Investigati Could not determine	be 28e. Place		At home, far		actory, office b	uilding, etc.	. 2	8f. Location (Street and Number		ral Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier 1 Certify Check only 2 Medica	Examine		of examinati	_						se(s) and manner a and place, and du		1
	ž	29b. Signature and title of	ertifier	Y 5%	ee d	3086)	29c. License O.C.M		<u>-</u>		29d. Date signed October 19,		
Phy		30. Name and address of p		completed caus			900 W. I	Baltimore S	treet, Ba	ltimore	, MD 2122	23		
Sta Registr	_	31. Date filed (Month, Day,	(ear) 2 8 20	32 Ae	gistrar's Sig	gnatur	park	V						

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** Honore . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Security Number **Funeral** 1 M 2 D F Country) GA (Month, Day, GN 25 Months Days Hours Min. 256-14-909 **Director** Usual Residence of Decedent shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director 28a-f 1 Pres 2 No mar 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral omen 21202 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 12. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ MOX 19a, Informant's Name/Relationship (Type, Print) Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or 110 Balfimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 UY 21. Signat 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betwee Onset and Deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 🗌 No To the Hospital or Attending Physician: The law requires that the dea 1 Yes 2 L 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tribute to the cause of death? 23e. Did tobacco use co Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has I autopsy perform death? 1 Yes To Be 25. Was case refe fed to n 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending injury work? 2 No Accident Suicide Investigation
6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

11-07907 Julian Benson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ulian Benson		State of Maryland / Department of Health and Mental H 1-For State Certificate of Death	lygiene	201	3439
Physicia	ال	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea	teg. 140.	3. Time of Death
Aedical Examin	er	Julian Benson	Month October 2	Day Year 20, 2011	2301 hrs
	H	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore	h	4c. County of Death	7
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		Foreig	thplace (State or
Director		146-90-0416 1 MM 2 F 23 Yrs.	April	8, 1988 co	untry) NJ
king.	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
. ₹	٦	NJ HINElla			1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cour	ntry?
with th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		0- 14. Race - Ameri	can Indian, Black,
or iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.	lack
irs after	≱	3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	Specify: 16b. Kind of Business/I	,
5 72 hound and and Example 1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use ret		0 11	
5-0036 lled within 7 Hygiene. I other than	틹	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (Eiret Middle	Maiden Surname)	ge
	Be C	Brett Benson Jen	ni fer	- John	son
D 2121 should be f and Mental is marked		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or land)	Rural Route Nu	mber, City or Town, State	Zip Code)
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumat	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
MOFC Pages 1 tent of H unt: If i		1 Burial 2 Peremation 3 Removal from State Perlin Cemetery W	29/2011	Berlin	NT
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27	1	21. Standure of Funeral Scale Lice se 22. Name and Address of acility	owell	Funeral	Hone
Physician	1	23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	e gnt		Approximate Interval
Medicul Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Blunt Force Injuries			Between Onset and Death
zammer		or condition resulting in death) Due to (or as a consequence of):			
	<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
ed Isit	티	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
		UNPENDED AMENDED			
760, ficate b g physic the bu		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregna		23d. Date of delivery	
Box 6876(death certificate the attending phyself for use as the b	cial E	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	ancy	Month E	Day Year
Bo the deat y the at	Phys	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did t	obacco use contribute to	the cause of death?
Division of Vital Records, P.O. Estal or Attending Physician: The law requires that the dreath. Al Director: After this certificate has been signed by the funeral director, page 2 should be detached.	2	Take the significant contained to the part but the tribet spring cause given in the circle syring cause given given given in the circle syring cause given give		s 2 No 3 Prob	
ords, w requires been should	ete		24a. Was		topsy findings available ompletion of cause of
Recc The lar icate ha	Completed			ormed? death? 2 No 1 ✓ Ye	s 2 No
Vital Reorganica The his certificate director, page	å l	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 Nursir		Residence 6 Other	
of Viring Physic	랅	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	
sion ttendir death. ctor: A		1 Natural 5 Pending Oct 20, 2011 2228 hrs 1 Yes 2 No		auto collision	
Division pital or Atten ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street	or Town,	Street and Number or Ru State) way @ Bank Street, Ba	
	हु	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)			
To wit	ĕ	29b. Signature and title of certifier. 29c. License number		29d. Date signed (Mor	nth, Day, Year)
		O.C.M.E.		October 21, 2011	
5 gm		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltin	nore, MD 21	223	
Sta	_	31. Date filed (Month, Day Year) 32. Registrars Signature			
Registr	ar_	OCT 28 2011 Jenera S. Jacks		OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland		irtment of F tificate of L			201	1 34395		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	incate of L	Jean	2. Date of Death	eg. No. <u>C</u> U I			
	Physicia Medic		Mose	Burgess				O CHUBER	24, 21,	3. Time of Death		
1	Examin		4a. Facility Name (if not institution, give s Maryland Ger	treet and number) NERAL KOSPIT	al		Location of Death	4	4c. County of De			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign Country) MD		
a.	Director		218-62-5677 Usual Residence of Decedent	M 2 □ F 55	Yrs.			0 7-0.9ay,	56	MD MD		
	rland f show	tor	10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits		
	Mary 28a-1 otifie	irec	MD NA	P	Baltin					1XXYes 2 ☐ No		
	ith the 23a or st be i	rai	10e. Street and Number 908 N. Bentalo	u Stroot		10f. Zip Code 2121	16	10	0g. Citizen of What USA	Country?		
	eath w	Funeral Director		12. Was Decedent Ever in U.S	i. 13. V		ispanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-		merican Indian, hite, et&frican		
9	after d ", or i kamin		1X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Yes, specify Cuba		rican, etc.)		hite, etqAfr1can nerican		
3	nours a	etec	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates.	16a. Deced	ent's Usual Occup	ation	- 1	16b. Kind of Busine			
212	be filed within 72 hours after death with the Maryland ental Hygiene. Red other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at	Completed by	(Specify only highest grad		(Give k life. DC	ind of work done of NOT use retired)	during most of work	ing				
12	d with tygien ther tl nt, the	Be C	Elementary/Seconday (0-12) 12th Grade 17. Father's Name (First, Middle, Last)	College (1-4 or 5+)	Disa	bled	40.14.11.11	ari a Nava da An	Disable	ed		
Maryland 21215-0036	ould be file d Mental H marked o matic eve	To E	Moses	Burgess			Isabel	ie (First, Middle, M. L1e	B rown			
lary	age 1 and 2 should be int of Health and Ment t: If item 27 is marked or other traumatic e		19a. Informant's Name/Relationship (Typ	· ·					City or Town, State,			
	pe 1 and 2 t of Health If item 27 or other tr		Geraldine Burge		1	N. Ben			altimore	e, MD 21216		
TO T	Page 1 nent of ant: If it any or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, crem	em. Pk.	:e) !	Date 29-11	•	lstown, MD		
Baltimore,	permit. Page Department Important: II any injury or once.		21. Signature of Funeral Service License		22.	Name and Addre	ss of Facility W	lie Fu	neral Ho	ome P.A.		
n	20 E 6 6	00. 0	1/1/1/14	nll						e,MD 21217		
			23a. Part 1. Enter the disease, or ompli shock, or heart failure. List only one Immediate Cause (Final	ications that caused the death e cause in each line.	. Do not ente	0		or respiratory arres	δ τ ,	Approximate Interval Between Onset and Death		
	Medical		disease or condition resulting in death)	a. yue (or as a conseque		brosis	noma			1		
	Examiner	<u>_</u>	Sequentially list conditions,									
	sit sit	mine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury									
	execution and ial-tran	Еха	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):				-			
3	te be executed hysician and he burial-transi	dical Examiner		i								
200	certifica nding pl	/Me	IF FEMALE: 23b, Was decedent pregnant 2	3c. If <u>ye</u> s, outcome of <u>pre</u> gnar	ncv				00d Date of	deliver		
Rox	death c he atten ied for us	Physician/Me	in the past 12 months?	1 Live Birth 2 Fetal 4 Pregnant at time of d	Ideath 3 🗀	Ectopic pregnand Other (specify)	су		23d. Date of Month	Day Year		
5	it the d by the stacher	Phys	g 🗆 Unknown	9 Unknown	Iting in the	adarbijaa aayaa ai	on in Part I	an Pilli				
s, P.O	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by	Part II. Other significant conditions con	tributing to death but not rest	alling in the ur	idenying cause gr	ven in Part I.			e to the cause of death? Probably 4 Unknown		
Hecords,	v requi	olete						24a. Was an		autopsy findings available		
Sec.	The law ate has bage 2 t	Completed	•					autopsy perform 1 \square Yes 2	ned? death	to completion of cause of 1? Yes 2 No		
Vital	ician: certific ector,	Be	25. Was case referred to medical examiner?	ospital:		26. Pl	ace of Death (Chec					
<u> </u>	ding Physician: The lath. After this certificate hatfuneral director, page	<u>ان</u>	1 ☐ Yes 2 ☑ No ☐ ☐ 27. Manner of Death	1 Inpatient 2 1	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injur	4	ome 5 Resider	nce 6 Other (Sp.	pecify)		
- 0	ath. rr. Afte ne fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work	Yes 2 No		,,	Injury occurred		
DIVISION OT	or Atter de lifter de Jirecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		et, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
ב ב	to the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director, After this certificate has a completed filled in by the funeral director, page 2 secondinates.	edical (cian: To the best of my knowle								
:	in 24 h	Med		er: On the basis of examination Practioner: To the best of my								
	Nith To 1		29b. Signature and title of certifier	Stre		29c. License	a number	29	Id. Date signed (Mo	onth, Day, Year)		
	46		30. Name and address of person who co	F 7	23a) Jīvne. P	pintly =	7 400	, (1	10127/	/ /		
	΄υ'		Sangue Sha	estha m	· D.	To Ma	eyland	- Grene	ral Ho.	spital		
	Stat Registra		31. Date filed (Mooth OCT 28 20	32. Fegistrar's Signati	d.	arkel	~					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROSALIE MAY BODEN OCTOBER 2011 10:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE BALTIMORE TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 213-26-2702
Usual Residence of Decede **Director** 1 □ M 2 🕱 F 83 Yrs APRIL 1,1928 MD 28a-f shov 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD BALTIMORE BALTIMORE 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 5692 UTRECHT RD 21206 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM DOENGES ELSA MAY CARNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other to once JAMES BODEN-HUSBAND 5692 UTRECHT RD BALTIMORE, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH Donation 5 Other (Specify) 10/27/11 BALTIMORE, MD Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC Signatu 6415 BELAIR RD BALTIMORE, MD 21206 23a. Par 1. Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart jailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) enahnovasci Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) The law requires that the death certificate be executed Cause (Disease or injury and -trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 N 2 XNO Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pending neral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be

101

To the

within 24 hours a

To the Funeral C

completely filled

Medical

29a. Certifier

31. Date filed (

y one

Division of Vital Records, P.O. Box 68760

State Registrar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0071287

npleted cause of death (Item 23a) (Type, Print) St. Suite 4195, Baltimere, Mo 21204

3 🗌 🔾 rtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 VIRGINIA MARIE BURNETT 2011 4a. Facility Name (if not institution, give street and number, 4b. City Town, or Location of Death 4c. County of Death BELAIR HEALTH AND REHAB HARFOR If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2 🗓 F Months Hours Min 2/2077P918 MD 93 <u>214-20-2163</u> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes X☐ No HARFORD BEL AIR 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 E. MACPHAIL RD 21014 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER

20b. Place of Disposition (Name of

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of

Due to (or as a consequence of):

Due to (or as a consequence of):

Pregnant at time of death

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office

ise of death (Item 23a) (Type, Print)

28b. Time of

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Unknown

28a. Date of injury

(Month, Day, Year)

building, etc. (Specify)

Nor

Hospital

PARKWOOD CEMETERY

6415 BELAIR RD

3 Ectopic pregnancy

5 Other (specify)

18. Mother's Name (First, Middle, Maiden Surname)

22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC

24a. Was an autopsy

4 Nursing Home 5 - Residence 6 - Other (Specify,

26. Place of Death (Check only one)

Other:

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

work

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

yes 2 No

28d. Describe how injury occurred

BALTIMORE, MD 21206

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2-☐ No

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown

Approximate Interval Between Onset and Death

15 mos

Year

BALTIMORE, MD

CATHERINE COTTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $303\ LABURNUM\ RD\ EDGEWOOD$, MD. 21040

10/28/11

Physician/ Medical Examiner Examine

Physician/

Medical

10a. State

MD

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)

Senature of Funeral Service Licens

SHARON POWELL-GRANDDAUTHER

1 XBurial 2 Cremation 3 Removal from State

SAMUEL MOORE

20a. Method of Disposition

Sel

Immediate Cause (Final

Sequentially list conditions

if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

1 Yes 2 No

25. Was case referred to medical

29b. Signature and title of certifier

30. Name and address of person who

5 Pending

Investigation

determined

6 Could not be

1 ☐ Yes 2 No

27. Manner of Death

Natural

Accident

3 Suicide 4 Homicide

29a. Certifier

disease or condition

resulting in death)

that initiated events resulting in death) Last

IF FEMALE:

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

should be filed within 72 I and Mental Hygiene.

permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic.

other traumatic event,

sician and burial-transit attending pl for use as t the funeral director, page

signed by

Physician/Medical

Completed by

Be

은

Certificate:

Medical

Records. Hospital or Attending Physician: The 24 hours after death. M

within 24 hours after death To the Funeral Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34398 Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ² 2 6 2011 Physician/ YEVGENIY OCTOBER BEKKERMAN 02:15A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 46 JONES VALLEY CIRCLE BALTIMORE BALTIMORE 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number Year If Under 24 Hrs. Min Hours 220-29-3310 **Director** 1 **X** M 2 □ F 77 07/20/1934 RUSSIA iral", or items 23a or 28a-f show Examiner must be notified at death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE MD BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 46 JONES VALLEY CIRCLE 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Yes : Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates WHITE other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ DENTIST MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ NATAN BEKKERMAN IDA GANTMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYUDMILA BEKKERMAN/WIFE 46 JONES VALLEY CIRCLE, BALTIMORE, MD 21209 20a. Method of Disposition
1

Mathematical Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 10/27/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee ouce. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sart failure. List only one cause on each line. shock, or beart failu Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Exami and burial-trar Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a detached f 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autons certificate 1 Yes 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: |₽ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral 27. Manne f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 4 hours after death. •uneral Director: Aft ely filled in by the ful ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a To the Funeral Completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Vino 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

8

MV

Physician/ Medical

Division of Vital Records, P.O. Box 68760

	T = State Registrar	Cer	tificate of Death	7	Reg	No. 2		31,399
	Decedent's Name (First, Middle, Last)				2. Date of Death			3. Time of Death
า/ al	RONALD BOOKER				$10^{-1}16-2$	0°11	Year	2:40 А м
ai er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location	n of Death		4c. County	of Death	1
	3366 Curtis Drive, #303	1	Suitland			Prin	ce (George's
		e (In yrs. last birthday)			8. Date of Birth		9. Birtl	hplace (State or Foreign
	247-80-5900 ¹\\XM2\\F	61 Yrs.	Months Days Hours	Min.	06-29-1	950	Cou	hplace (State or Foreign Intry) S C
	Usual Residence of Decedent							
tor	10a. State 10b. County	10c. City, Town or Lo						10d. Inside City Limits
rec	MD Prince George's	s Suitlan	d					1 X Yes 2 No
	10e. Street and Number		10f. Zip Code		10g	. Citizen of	What Co	untry?
era	3366 Curtis Drive, #30	1	2074	6		USA		
ᆵ	11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of Hispanic C f Yes, specify Cuban, Mexic	Origin? (Spec	ify Yes or No-			ican Indian,
þ	1 Never Married 2 Married 1 Yes 2 X	No	Yes 2 No Specif		noari, ctc.)	Bla	ck, White $_{:}$ $\mathrm{B1}$ s	e, etc. e.c.k
ted	3 Widowed 4 Divorced Year or Dates.		TES ZEINO Specia	ny.		Specify		
ple	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during me	ast of working	g 16	b. Kind of B	usiness I	ndustry
Completed by Funeral Director	Elementary/Seconday (0-12) College (1-4 or 5	ife. D	O NOT use retired)	,	·	1	1 0.	
BeC	12th	Equi	pment Oper					overnment
To B	17. Father's Name (First, Middle, Last)				(First, Middle, Mai		e)	
H	William Thomas Booker		Ja	nie G	ilcrest			
	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Num					
	Harriet E. Booker/wife	3366	Curtis Dr	., #30	1, Suit	land	, MI	0 20746
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo	natony or other place)	i		c. Location		
	4 Donation 5 Other (Specify)	Cedar Hi	11 Cem.	10-22	-2011 Si	ıitla	nd,	Maryland
	21. Signature of Funeral Service Licensee	22	. Name and Address of Fac	oility	7 7			20746
	Tihn Li Beed	Ç e	dar Hill F	H,411	1 PA Av	re.,S	uıt.	Land, MD
	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente	er the mode of dying, such a	as cardiac or	respiratory arrest,			Approximate Interval Between
	Immediate Cause (Final		al Cell Car	ncor				Onset and Death
d		a consequence of):	ai ceii cai	1001			_	
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a	a consequence of):						
Examiner	Cause (Disease or linjury that initiated events c.							
Ĕ	resulting in death) Last Due to (or as:	a consequence of):						
ca	d							
Medical						_		
_	IF FEMALE: 23c. If yes, outcome 23c. If yes, outcome		7			23d. Da	te of deli	ivery
200	1 Yes 2 No 4 Pregnant a	2 Fetal death 3 L t time of death 5	Other (specify)			Mo	onth	Day Year
, T	9 Unknown							
To Be Completed by Physician	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause given in Pa	art I.	23e. Did tobac	co use cont	ribute to	the cause of death?
ed ed	<u> </u>				1 ☐ Yes	2 🗌 No	3 X Pr	obably 4 🗆 Unknown
Set					24a. Was an			opsy findings available
Ē		<u> </u>			autopsy performe	d?	death?	completion of cause of
Č o	25. Was case referred to medical		26. Place of De	eath (Check o	1 Yes 2 \$	U No	1 L Yes	2 🗆 No
0 8	examiner? 1 Yes 2 No Hospital:	ent 2 ER/Outpatier	Other		ne 5 🗓 Residenc	а в П О t h	or (Coosi	6.0
	27. Manner of Death 28a. Date of inju	ry 28b. Time of	28c. Injury at		8d. Describe how i			
cat	1 X Natural 5 Pending (Month, Day 2 Accident Investigation	, Year) injury	work? M 1 ☐ Yes 2	□No				
┋	3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, stre	eet, factory, office	2	8f. Location (Stree	t and Numb	er or Rur	al Route Number,
ဒီ	building, etc	c. (Specify)			City or Town, S	tate)		
Medical Certificate:	29a. Certifier 1X Certifying Physician: To the best of	my knowledge, death o	occured at the time, date an	nd place, and	due to the cause(s) and mann	er as sta	ted.
Ned	(Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner: To the	xamination and/or invest	tigation, in my opinion, death	occurred at the	he time, date and p	lace, and du	e to the c	ause(s) and manner stated.
	29b. Signature and title of certifier	^	29c. License number	r	29d	. Date signe	d ⁴∕lonth	, Day, Year)
	> Jocelyne Kouarch	roce, mo	D6370	48		10-22	-20	11
	30. Name and address of person who completed cause of d	eath (Item 23a) (Type. F	Print)					
	Jocelyne Kouatchou, MI			oad,	Calvert	on, I	MD.	,
		ar's Signatur					-	
	DOT O R 2011	. 1 16	2 Rad					

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death time itv Number If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 212-40-1058 Hours **Director** 1 🛮 M 2 🗆 F 69 Yrs. 02/8/1942 Maryland Show with the Maryland 10a, State 10b County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits 28a-f Maryland Harford Aberdeen 1 Xyes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 700 W. 21001 Bel Air Ave. Apt. 322 USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify SpeciWhite Completed 3 Widowed 4 Divorced Year or Dates er than "natur the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene.

If item 27 is marked other that or other traumatic event, the I 12 0 Insurance Agent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leonard Bailey Ethel Olsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Bailey / Wife 700 W. Bel Air Ave. Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
West Chester, ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place Department of Important: If any injury or Ferris & Co. 10/28/2011 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signatur of Francis Srvice 2 Name and Address of Facility Farring-Cargo Funeral Home, P.A. 33 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician Due to (or as a consequence of): disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) ò in the past 12 months? Month detached the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform certificate Yes 2 X No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2X No 1 Inpatient 2 ER/Outpatient 3 DOA
Date of injury 28b. Time of 28c Other: 1 Yes Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 124 hours after death.

Funeral Director: After letely filled in by the fur 5 Pending 2 Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical within 24 hours to the completely fi 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) OCTOBER 24,2011 RGS - GOO MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

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BALTIMORE

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31. Date filed (Month, Day, Year)

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		1- For State Registrar		Certi	ficate o	f Death			Reg. No.	201	1 3440
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Medical Exami	ner	John		ran, I	11			October	23, 20°		2246 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, 11521 Hannibal Road Glen Arm					r Location of Dea	th		County of Death	
Formand		5. Social Security Number 6. S	17 Ac	o /lo ven loci	hidhday		on I K Under Odli	lo p-1			•
Funeral Director		0.1 = 0.0 = 1 = 1		e (In yrs. las	(Биппаау)	If Under 1 Year Months Day		n.		DD/YYYY) 9. Biri Foreig	ın
Birector			M 2 F	35	Yrs			Aug.	23,	1976 ^c	untr Maryland
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ter de	리	3 Widowed 4 Divorce	1 Yes 2 d If Yes, Give Year	X No	\prod_{1}	Yes 2 X No	n snecify:			Specify: Whi	te
urs af tural	ğ	15. Decedent's Education (Specify of	or Dates:	pleted) 1	6a. Deceder	it's Usual Occupa	ation (Give kind of	work done		(ind of Business/I	
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or		during m	ost of working life	e. DO NOT use re	tired)			,
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5-0 ed wi	ड	17. Father's Name (First, Middle, Las	1)	l			18.Mother's Nam	e (First, Middle,	Maiden	Surname)	
be fill mtal F	å	John C. Corckr						Fenhag			
bould Me is ma	의	19a. Informant's Name/Relationship (ty or Town, State	
ME and 2 s alth an m 27 aum.	J	John C. Corckran	, Jr./ Fat							D. 2121	
S and		20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from Sta		ce of Dispos matory or oth	ition (Name of ce ner place)	emetery,	Date	20c. l	ocation - City or	Town, State
Page Page nent ant:	Щ	4 Donation 5 Other Specifi			top S	ervice C	Co. 10-	-31-11	T	Towson, 1	MD.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f abov injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature uneral Service Li	see		22. N	lame and Addres KUCK	Towson I	Tuneral	Home	Inc.	
	-4	1111	1			1050	York Rd.	Lowson	I, ML). 21204	
Physician /Medical	- 1	23a. Part V Enter The dispase, or or m failure. List only on cause on e		the death. D	o not enter ti	ne mode of dying,	, such as cardiac	or respiratory ar	rrest, sho	ck, or heart	Approximate Interval Between Onset and
zxaminer	- 1		Acute Pne								Death
	- 1	or condition resulting in death)	Due to (or as a conse	equence of):							
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^	틝	cause. Enter Underlying Cause (Disease or injury that initiated									
DYC B E	<u>R</u>	events resulting in death) Last	Due to (or as a conse	equence of):							
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			AMENDED 2 3 & ;	, pr. II	, 27 , pe	пе, ду.	ZZ 1Z-9-	II SII			
Box 68760, s death certificate be the attending physicist for use as the buring of the buring the b		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcon	ne of pregnar	· — -	tal death 3	Ectopic pregn	anov		. Date of delivery Month D	ay Year
x 687 h certifi tending use as t	Cia.	past 12 months?		time of death		ner (Specify)		aricy		HOTEL D	ay real
BO.	lys.	1 Yes 2 No 9 Unknow	9 Unknown			_					
P.O.		Part II. Other significant conditions	contributing to death	but not resu	lting in the u	nderlying cause g	given in Part I.				he cause of death?
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tal Recian: The certificate		25. Was case referred to medical				26.Place	of Death (Check		2 NO	1 Y Ye	s 2 No
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e = . `@	흥	1 X Natural 5 Pending		1		1 🗆 ነ	Yes 2 No				
Division tal or Attendi rs after death. al Director: A	<u> </u>	2 Accident Investigat 3 Suicide 6 Could not	28a Place of Ini	ury - At home	, farm, stree	t, factory, office b	ouilding, etc.			nd Number or Run	al Route Number, City
DIV pital or ours afte ceral Dir filled in	Certification:	4 Homicide determine						or Town,	State)		
/ o- = >	_		ian: To the best of my								
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examine	COn the basis of exame and manner stated.	nination and/	or investigati	on, in my opinion	n, death occurred	at the time, date	and place	ce, and due to the	cause(s)
	Σĺ	29b. Signature and title of certifier	\cap			29c. Licens	e number		29d. D	ate signed (Mon	th, Day, Year)
		1 H clube	u			O.C.1	M.E.		Octo	ber 24, 2011	
Q		Name and address of person who			•				, C		
۲			tant Medical Exa		00 W. Ba	Itimore Stree	t, Baltimore,	MD 21223			
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	's Signature		9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1044 AM ctober 22 2011 ooper 101a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA Baltimore Hospital Baltimore 0 } If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, OC+ 8) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 1 □ M 2 🖫 F 217-26-9006 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f shov other traumatic event, the Madical Examiner must be notified at 1 Nes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Neyer Married 2 ☐ Married 2 106 Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No δ 3 Widowed permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exagines. 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) KNOWN OS. Elementary/Secondary (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) tat vens 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patient MD Ito. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 ☐ Removal From State 1 Berial 2 ☐ Cremation) WINGS 4 ☐ Donation 3 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License reval towell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 30 failure **Physician** minutes vesoivatory disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Car diag enio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed CarcAIDI myo Cardial physician and s the burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, disease ardiovas cular attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy 2 00 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Yes 2 No 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Natural Accident 5 Pending investigation 2 No 1 ☐ Yes 24 hours after death, Funeral Director: A the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D66108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital - Baltimore Year) 31. Date filed (Month, Day, State 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5110f &16har Pland The G920 10/31/2011 and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Contar Daniel JOSEPH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death Prince Hospital Regional 9. Birthplace (State on Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Director 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No 10f. Zip Code 20724 10g. Citizen of What Country? Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, marked other than "natural", or iter matic event, the Medical Examiner Armed Forces? Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK If Yes, Give Year or Dates 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) OSEDA 19a. Informant's Name/Relationship (Type, Print) \$15TER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ELKRINGE, MA 23a. Part 1. Efficience Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 01 Due til () as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Cardpanyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 2 🗌 No 25. Was case referrence examiner?

1 Yes 2 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 \(\sum \) Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Karuny ω D68782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 25 20 11 Month Physician/ THOMAS CICCANTI 10 08:4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNION MEMORIAL BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 ¥ M 2 □ F 80 274-38-2205 ITALY JULY 13,1931 Director Yrs. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at 10a State Director 1 🗌 Yes 2 🔀 No BALTO. NOTTINGHAM MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be n USA Funeral 21236 APT.D 9103 LINCOLNSHIRE CT. items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Black, White, etc. 1 Never Married 2 Married ō þ Yes 2X No Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Je filed wto... *al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) CONTRACTOR ELECTRICIAN Be 17. Father's Name (First. Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filk and Mental I ပ EMIDIO CICCANTI ANTONIETTA PICCINNI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or Attachment of Attachmen APT.D NOTTINGHAM, MD. 21236 9103 LINCOLNSHIRE CT. **SPOUSE** IRENE CICCANTI Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY 10-27-2011 GLEN BURNIE, MD. 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. Signature of Funeral Service Licensee NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due t for as a consequence of): Examiner obstructive sleep Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Right Ventricular Cause (Disease or injury that initiated events resulting in death) Last g physician and as the burial-transi to (or as a consequence of): Restrictive Lung Visease Secondary to Scotiusis Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Failure 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 Jas page 2 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) n 24 hours after occur.
he Funeral Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending work? 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 24 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number AT 2438946 10, 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PORKWAU MD 21218 Tue Wana Baltimore East University 31. Date filed (Month State 28 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dear **7:10A** Physician/ DR. CORTEZ ALONZO COOPER 25, 2011 DCTOBER Medical or Location of Death a. Facility Name (if not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER 4c. County of Death BALTIMORE Examiner TOWSON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 10/6/1931 **X** _{M 2 □ F} 252-46-6748 Director GEORGIA 80 Yrs 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Maryland Director notified 28a-f N/A LYNCHBURG 1X Yes 2 No VA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò .s 23a о, r must b Funeral 201 HARRISON STREET 24504 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other ##~ " any injury or other train any injury or other train and permitted." "natural", or iter Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 2 🗌 No 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 5+ YEARS Elementary/Secondary (0-12) MINISTRY MINISTER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည BILLIE DEKLE CORTEZ ALONZO COOPER, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA SARTELLE COOPER/WIFE 201 HARRISON STREET LYNCHBURG, VA 20b. Place of Disposition (Name of DRAPER/CSMVALSURY PRES-20a. Method of Disposition Date 1X Burial 2 Cremation 3 Removal from State BYTERIAN CH. CEM. 10/29/2011 DRAPER, VA 4 Donation 5 Other (Speglify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME MO1139 21. Signatu of Funeral Service 8521 LOCH RAVEN BLVD. TOWSON, MD a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between OHOUKS** Immediate Cause (Final VENTRICULAR ARRHYTHMIA Physician/ disease or condition Medical resulting in death) 10 HOURS Due to (or as a consequence of) Examiner ACUTE CORONARY SYNDROME Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examin Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 5 Other (specify) signed by the at be detached for Yes 2 No 1 L Yes 2 L 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ **HEMOTHORAX** 2 X No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2X No page 2 death? 1 Yes 2 No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X**No 1 Tyes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical

24 hours after death. Funeral Director: A within 24 hor To the Fune completely f

> State Registrar

29a. Certifier

(Check

only one)

29b. Signature and file of

3

30. Name and address of person who completed c PREETAM JOLEPALEM 7601 OSLER DRIVE TOWSON, MD 21204 32. Registrar's Sanature

erson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number D65045

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For Amend Item 21	State of May26	nfb/ 287 Cei	2011 of He	alth an eath	d Mental Hyg	jiene Reg. No. 2	34406	
		1	Registrar Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death	
	Physicia		Jean Elizabeth Co.	lburn				Sept		2011 11:00 A M	
	Medic Examin		a. Facility Name (if not institution, give str	reet and number)		4b. City, Town, or Lo				y of Death	
1			6503 Ridge Road	7 0 - 7 0 - 110	. last birthday)	Mt Airy	If Under 24	Hrs. 8. Date of Birt	Carroll Birth 9. Birthplace (State or Foreign		
1	Funeral Director	5	Social Security Number 6. Sex	M 2 🔀 F 87	Yrs.			Min. (Month, Day 5/8/19	24	9. Birthplace (State or Foreign Country) DC	
			Usual Residence of Decedent	0,		eastion				10d. Inside City Limits	
	f sho	tor	10a. State 10b. County		City, Town or Lo	ocation				1 ☐ Yes 2 🙀 No	
	Man 28a- notifie	Director	MD Carrol1	M	Airy	10f. Zip Code			10g. Citizen of	What Country?	
	ith the		6503 Ridge Road			2177	1			USA	
36	nit. Page 1 and 2 should be filed within 72 hours after death with the may rain of the flether and Mental Hygiene. ordant: If them 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at e.	by F	11. Marital Status	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 🔀 No	Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		ice - American Indian, ack, White, etc. fy: white	
Ö	ours a	etec	15. Decedent's Edu	Year or Dates.	16a. Dece	edent's Usual Occupat	ion	addaa	16b. Kind of I	Business/Industry	
7.	an "na Media	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4 or 5+)	life.	e kind of work done du DO NOT use retired)			D.C.	Government	
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nd	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last)					ian Burto		nej	
yla	uld be d Men narke natic	-	Bert Swartz 19a. Informant's Name/Relationship (Type	e Print)	19h Mai	iling Address (Street ar				State, Zip Code)	
	2 should th and Me 27 is mar traumati		Dawn Bay/daughter	e, r ning	650	03 Ridge R	oad, M	Mt. Airy M	D 21771		
<u>စ</u> ်	Heal Heal Heal	1	20a. Method of Disposition		b. Place of Disp	position (Name of ematory or other place)	Date	l .	n - City or Town, State	
ШO	age lent of nt: If in ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		fort Li	ncoln Cem		9/29/2011		ntwood, MD	
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other i		21. Signature of Funeral Service License James B. Cove		rR	22. Name and Address 1212 W Old	s of Facility Libe:	Burrier-C	ueen Fi Iinfield	ineral Home i MD 21784	
0	Physician/ Medical Examiner Period Medical Medical Medical Medical Medical	ical Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e cause on each line.	y Heart sequence of): nsion sequence of):	Disease	, 300/100 00			Interval Between Onset and Death	
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	E S E Ö		> 7 drand	+ the	M	0003	6610		1 10	01312011	
			30. Name and address of person who of Edward Fisher,	Hayward Pro	fession	al Center,	, 56 Т	homas Johi	nson Dr	, Ste 200, 21702	
	St Regis	ate trar	31. Date filed (Month, Day, Year) 0CT 2 8 2011	32. Registrar's S	Signature for	extel					

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			Registrar				C	ertificate	of D	eath			Reg.	No. 4 U	1 1	34407
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	show at	or	Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or I	ocation							1	0d. Inside City Limits
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	a or h	al Di	10e. Street and Nur	mber				10f. Zip C	ode				10g.	Citizen of WI	hat Cour	itry?
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Elille , Alic Baltimore, Maryland	power, age, a fact a subout be track whith 7.2 hours aren death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 🔀 Burial 2		3 Removal from			oosition (Name o)	1	Date	20c.	Location - C	ity or To	wn, State
ifir.	Department of High portant: If its any injury or ot once.		4 Donation 21. Ignature of Ful	5 Other (Sp		_ Kir	ng Me	morial	L_Pa	ark	10/	28/2	otr	Woodl	awn	. Md
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rds,	sen siç	ted	COP	D								1	☐ Yes	2 🗀 No 3	☐ Prob	ably 4 🗆 Unknown
SCO!	has be	age										a	Vas an utopsy	pric	or to con	sy findings available pletion of cause of
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on endir	death. ctor: Aff y the fur	lica	1 ✓ latural 2 — Accident 3 — Suicide	5 Pending Investiga	tion	i, Day, Tear)	injury		work? 1 🔲 Ye	es 2 🗀	No					
ĕ Š.	within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Certificate:	4 Homicide	6 ☐ Could no determin	28e. Place	of Injury - At hor g, etc. <i>(Specify)</i>	me, farm, st	reet, factory, of	fice		:		n (Street a Town, Stat		or Rural I	Route Number,
Cospita	24 hours Funeral eted filled	Medical	29a. Certifier 1 (Check 2	Certifying P	hysician: To the be	st of my knowle	edge, death	occured at the	time, d	late and p	lace, and	d due to the	cause(s) a	and manner a	as stated	
the H	within 24 To the F complete		only one) 3	Certifying N	urse Practioner: To	the best of my	knowledge,	death occurred	at the ti	ime, date	curred at and place	the time, da e, and due t	te and place the cause	ce, and due to e(s) and mann	o the cau er as sta	se(s) and manner stated, ted.
6	₩ 2 0	2	9b. Signature and ti	tle of certifier	OAS	٠, ١		29c. Lic	cense n	umber	_			ate signed (A		2 / 2
1			0. Name and address	m	o completed	of doub "	220\ 7	District)	5	5/-	6 د	,		doh		27,2011
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/X DHWH	17 Rev 7/200	g														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 34408 Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26° 2011 October 10:00 P Elizabeth Gill Dougherty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Social Security Number 6. Sex 9. Birthplace (State or Foreign Days 1 M 2 K F Hours June 24, 1921 Virginia 90 Yrs. **Director** 227-18-5782 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23° ---- any injury or other traumatic event, the Marie 1000cg. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Columbia 1 Yes 2XXNo Maryland Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21044 10053 Windstream Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2XX No If Yes, Give Year or Dates. by 1 Never Married 2 Married 1 Yes 2 X No Specify. Specify: White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Mary E. Ames Frank C. Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore M. Dougherty Clarksville, Maryland 21029 12921 Kentbury Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place 10-31-2011 Columbia, Maryland Christ Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee

22. Name and Address of Facility

3555 Twin Knolls Road Columbia, No.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Witzke Funeral Homes, Columbia, Maryland 21045 Interval Between Onset and Death Physician/ With unknown Lancer disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to in mediate cause. Enter Underlying Examiner Due to for as a nonsequence of, Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 124 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the at d be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Cardiomyopathy Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an r this certificate has ral director, page 2 autopsy funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) HOS Pi Ce 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 5 Pending injury 1 Natural 2 🗌 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the I within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D0060634 10/27/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State

Registrar

EDAR LANE

2. Registrar's Signature

MD

COLUMBIA

210 44

6336

BINDU JOSEPH

28201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCTOBER. Physician/ 201° DICKENS 10:10P M MARTHA ALICE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S LARGO MANOR CARE LARGO 9 Birthplace (State or Foreign Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** OCT · 2 1 □ M 2 🛚 F Days Hours NORTH CAROLINA 1906 105 239-60-1993 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Yes 2 No PRINCE GEORGE'S MD CAPITOL HEIGHTS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral with 20743 USA 410 BALBOA AVENUE hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🚺 No Black White, etc. 1 Yes δ 1 Never Married 2 Married SpecifyAFRICAN AMERICAN Maryland 21215-0036 1 ☐ Yes 2X No 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC WORKER PRIVATE should be filed with and Mental Hygien 7 is marked other the 5th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JENNY. BROWN BEN MITCHELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau AVENUE CAPITOL HEIGHTS, MARYLAND 20743 MARY ANN LITTLEJOHN/DGT Baltimore, 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State TARBORO, NORTH CAROLINA FREE UNION BAPT. CHURCH 10/29/11 4 ☐ Donation 5 ☐ Other (Specify) JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility J. B. 21. Signature of Funeral Service License 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ADVANCED DEMENTIA Medical Due to (or as a consequence of) Examiner ANEMIA Sequentially list conditions, if any, leading to immediate cause. Liner Universitying Due to (or as a consequence of) Exam DEEP VEIN THROMBOSIS burial-transi Cause (Disease or liniury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the a d be detached f 1 L Yes 2 b 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No this certificate has death? 2 🔀 No 1 Yes Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medica examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ုင္ 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

OWEOWO 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

(Check

only one)

IBITOYE M.D. 12200 ANNAPOLIS ROAD #232 GLENN DALE, MARYLAND 20769 parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number D51437

29d. Date signed (Month, Day, Year)

2011

OCTOBER 24.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont aragret Dund Medical County of Death Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** paltimore entei OWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min. Director 1 □ M 2 💢 F 16 28a-f show 10a. State **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f s must be notified Phoenix 1 Yes 2 No altimor 10e. Street and Numbe 10g. Citizen of What Country? 2113 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner I 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nom e Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည INKnown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) cott cettsville hoenix MD 2113 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or 4 ☐ Donation 5 ☐ Other (Specify) 10/26/11 rocest Hill 22. Name and Address of Facility 2325 21. Signature of Funeral Service Licenses York Rd. Timonium MD 21093 ives Funera renation Center or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest st only one cause on each line: . Part 1. Enter the disease, or comp shock, or heart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit resulting in death) Last Due to (or as a consequence of). attending physician for use as the buria Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Year Day Pregnant at time of death 1 Yes 2 No Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? à Records, 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has certificate 2 No Yes 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 2 No 1 Yes Accident Investigation Accider
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nature and Atle 8611000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

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Department of Health an Important; If item 27 is any injury or other trau

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After this

after death.

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Completed by

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Certificate:

Medical

burial physician s the burial

other traumatic

2

The law r certificate has

the Hospital or Attending Physician:

4a. Facility Name (if not institution, give street and number) Hospital Square 1 **X** M 2 □ F 78

7. Age (In yrs. last birthday 10c. City, Town or Location

Rosedale If Under 1 Year | If Under 24 Hrs. Days Hours

Parkville

10f. Zip Code

4b. City, Town, or Location of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

> 8. Date of Birth May 23, Y Yel 933

2. Date of Death

10

timore 9. Birthplace (State or Foreign Maryland

3. Time of Death 9:10 PM

10d. Inside City Limits

1 🗌 Yes 🗶 🗆 No 10g. Citizen of What Country?

USA

4c. County of Death

3507 Quatman Avenue

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

21234

14. Race - American Indian, Black, White, etc. white

15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist

16b. Kind of Business Industry Bethlehem Steel Company

17. Father's Name (First, Middle, Last) Otis Vernon Deickman, Sr

18. Mother's Name (First, Middle, Maiden Surname) Lillian Thoman

19a. Informant's Name/Relationship (Type, Print) Betty Deickman-spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3507 Quatman Avenue-Parkville, Maryland 21234

1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

20c. Location - City or Town, State Oct. 28, 2011 Parkville, Maryland

shock, or heart failure. List only one cause on each line

22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death

disease or condition resulting in death)

Immediate Cause (Final

20a, Method of Disposition

Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Due to (or as	a consequence of	of):
 Rena	L Fai	luse
Due to (or as	d eonecquentes o	A):
	~ :	1

Pleural

Physician/Medical IF FEMALE: 23b. Was decedent pregnant

in the past 12 months?

1 Yes 2 No 9 Unknown

Live Birth 2 Fetal death Pregnant at time of death Unknown

3 Ectopic pregna 5 Other (specify) Ectopic pregnancy 23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medica 2 No 1 🗌 Yes

27. Manner of Death

1 Natural

29a. Certifier

(Check

Accident

Hospital 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year)

Other: 28c. Injury at work? 1 ☐ Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check only one)

Square Drive

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

performed ☐ Yes 2 🗹 No

Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) anna

D7022

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doratotal

5 Pending

Investigation

28b. Time of

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OC L. 20°, 20^Y1^a1 3:10A M James Dunaway, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Country) MD Days Hours Min 01-23-31 80 213-26-4451 Director 1 XM 2 □ F Usual Residence of Decedent 28a-f show 10a, State with the Maryland 10b. Coun 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Baltimore Baltimore 1 X Yes 2 No 10e. Street and Number P 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Agnes Lane Apt.#407 21207 1121 St. USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify Specify: American Completed 3 Nidowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) Englander Bedding Shipping & Receiving Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eula Dunaway Lombard Dunaway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122919a. Informant's Name/Relationship (Type, Print) Meta J. Hamlin-Daughter 610 Woodington Road Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1X Burial 2 \square Cremation 3 \square Removal from State 10-25-11 Baltimore, MD Loudon Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. N. Gilmor Street Baltimore, MD 21217 638 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ +ancreatic disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes Yes 2 X 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ္ 1 🗌 Yes MOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 October 20 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5701 N NOCWOT

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

and

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 26, per phy, g920 10-28-11 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2121 James, Dai Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospita Upper Chesapeake Har tor Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Date of Birtin (Month, Day, Year) 1 1940 9. Birthplace (State or Foreign Country) Maryland **1X** M 2 □ F Days Months Min. Hours **Director** 212-40-6422 70 Nov. Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2X No Maryland Harford Bel Air 10e. Street and Numbe ō 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral USA 21015 2006 East Churchville Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces? 1 ♣Yes 2 ☐ No If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Home Improvement Owner / Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Beulah Hanson Mitchell James Bernard Dayhoof Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 East Churchville Road, Bel Air, Maryland 21015 Joanne Fleming / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion UMC Cemetery 10/31/2011 Bel Air, Maryland Mt Signature Suneral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ cardiomyapat disease or condition resulting in death) Medical Due to (or as a cons uence of): Examiner : 0 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical / the attending phother of the design of the ched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ⊑ 9 ☐ Unknown Unknown After this certificate has been signed by a funeral director, page 2 should be detact Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗹 No 2.KJ No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 KER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Presidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 📐 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the boat of my including the course of the time date and place, and due to the cause(s) and manner at extending the course of the cause(s) and manner at extending the cause of the c (Check d at the time, date and place, and due to the cause(e) and manner as etate 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOOUPPER Chesapeake Or, Belair, MD Midalke Jeremy 31. Date filed (Month _ y, Year) 32. Pegistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2011 Physician/ 4:37 PM M October 9 Medical Helen N. Drolsum 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Taneytown Country Companions If Under Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours (Month, Day, Year) 353-18-4088 Director 1 - M 2 XF DEc 28, 1926 Illinois 84 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🖁 No MD CArrol1 Taneytown 20 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 4501 Babylon Road 21787 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. or i þ 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white "natural", 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ librarian education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Faye Burdette Davis Edna Mae Conklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christian D. Drolsum/son 2151 Chapel Valley Lane Lutherville, MD 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) 28 Partend Adda to Shay Board 655 W. Baltimore Street 21201 MD Baltimore, t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovasanlys Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of Exami that the death certificate be executed -tran Due to (or as a consequence of) resulting in death) Last burialiding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as JE FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No Por Month Dav Year the 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 has autopsy performed? certificate Yes 2 N or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 I funeral 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of LIVING Certificate: 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death. e Funeral Director: Aft bletely filled in by the fur Facility 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

29a. Certifier

29b. Signature and title of certifie

ohn Wm 31. Date filed fMonth, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hou To the Funel completely fi

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 17,18 per fh g921 II-1-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Debedent's Name (First, Middle, Last) 2. Date of Death October October Physician/ Day 0304 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. Gounty of Death Examiner 4b. City, Town, or Location of Death Agnes Hospita Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day 5. Social Security Number 7. Age (In yrs 9. Birthplace (State or Foreign Cot/htr/) last birthday) **Funeral** 1 M 2 D F Director Yrs Usual Residence of Decedent or 28a-f show 10a. State death with the Maryland 10b County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD 1 Yes 2 □ No Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 1154 items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc o, þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. 1 Yes 2 Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Secondaly (0-12) College (1-4 or 5+) State of MD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ٥ Briscoe Davis 141 Hettie Edmondson Informant's Name/Relationship (Type, Print: 19b. Mailing Address (Stree) and Number or Rura DUITO. alda. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other). 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licens 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition)

Sephic Shock Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2 days Aspiration pheumonia Sequentially list conditions, it cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner 2 days Small bowel obstruction the attending physician and hed for use as the burial-transit death certificate be executed Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for Month 5 Other (specify) Dav Year 9 ☐ Unknown law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has performed' the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 2 No Be | 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Tyes 잍 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Berilte 10/25/2011 24855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Murad Bani Hani, 900 Caton Avenue Ba Baltimore, MD 900 Caton Avenue 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Davis.

Please Type or Print in Black Indelible Ink./Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) George Fitez, Jr. 2. Date of Death Physician/ Month OCTOBER 2011 12:17A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Vorizen Assisted Living Pikesville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday)
71 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 □ F Hours Min. (Month, Day Year) 218-36-5437 Maryland Director 1940 Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number ò 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 200 Juniper Dr. 21060 United States 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Trucking other Be 17. Father's Name (First, Middle, Last) ent of Health and Mental Hat: If item 27 is marked ot y or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Raymond Fitez, Sr. Dorothy Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline L Whitten /Daughter 200 Juniper Dr. Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 31 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or once. Marriottsville, Marylan Crestlawn Memorial Park 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Nationatoion and Funeral Alternatives Rebecca 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin burial-transit and Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical that the death certificate be Box 68760 attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Division of Vital Records, P.O. signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ MELLITUS Completed 1 Yes 2 No 3 Probably 4 Unknown EREBROVASCUL 124a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 1198158 performe 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ASSISTED 1 🗆 Yes 2 🗷 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? EACILITY Certificate: 28b. Time of 28d. Describe how injury occurred 1 V Natural 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners T. the could of my knowledge, costs, occurred at the time, date and place, and due to the cause(e) and manner as stated. (Check 29b. Signature and titl 053095 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 TEXXS STATION COURT # 210 TIMONIUM, MARYLAND 21013 no 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month October 2011 2011 Natalie M.Felder 10:26 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gensis Healthcare-Hammonds Lane Center Brooklyn Park Anne Arundel Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🕅 F Days Director 213-86-7738 48 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 903 Stamford Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, r than "natural", or iter the Medical Examiner ģ 1 X Never Married 2 Married Yes Yes, Give Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 10th Deliverv Meals on Wheels injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ Thomas Felder Bennie L. Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Bennie L.Gee/Mother 903 Stamford Road, Baltimore, MD 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Louden Park Cemetery 10-27-2011 Baltimore, MD 21. Signature of Funeral 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year the the signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **N**O Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) eral Director: After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🕶 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatu

Registrar DHMH 17 Rev 7/2009

State

30. Name and

Box 68760

of Vital

Division

1845

dress of person who completed cause of death (Item 23a) (Type, Print)

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			Please Type or Print in Black State of Maryland / Dep		Лental Hygie	ene		
		_1	Tiegle trait	ertificate of Death		3. No 2011 34419		
	Physicia Medic	n/ al	1. Decedent's Name (First, Middle, Last) Elise Franklin		2. Date of Death Month OCTO HER	Day Year 7:00 1 M		
- meter his	Examin	er	4a. Facility Name (if not institution, give street and number) 11 Graywood Road	4b. City, Town, or Location of Death		4c. County of Death		
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Dunda1k If Under 1 Year I If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Birthplace (State or Foreign		
	Director		219-20-5731	Months Days Hours Min.	July 17	Pay, Year) Country)		
	2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	tor	10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits		
	e Man 28a- notifie)irec	MD Baltimore	Dunda		1 ☐ Yes 2X No		
	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Funeral Director	10e. Street and Number 11 Graywood Road	10f. Zip Code 21 222	10	g. Citizen of What Country?		
	eath w	-une	11 Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	United States 14. Race - American Indian,		
99	fter de	þ	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ No Specify:	Hican, etc.)	Black, White, etc. Specify:		
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75	72 ha	Completed	(Specify only highest grade completed) (Giv	edent's Osdai Occupation e kind of work done during most of work DO NOT use retired)	ting 1	6b. Kind of Business/Industry		
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nd	filed tal Hy of oth event	To Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma			
ryla	uld be I Meni narke	F	John James Rittenhouse		audia Bal			
Ma	2 sho th and 27 is r traun			iling Address (Street and Number or Rui 68 Chipwood Court				
e,	f Heal item	-	20a. Method of Disposition 20b. Place of Dis	position (Name of		Oc. Location - City or Town, State		
шo	Page nent o int: If iry or		Tel Bullar 2 - Oremation 5 - Hemovarion otate	ematory or other place) d Cemetery Oct	. 27,2011	Baltimore, MD		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.	-	21. Signature / Fuy ral / rvice/Lince (see	22. Name and Address of Facility Duda—Ruck Funera1 7922 Wise Ave Du	Home of I	Oundalk, Inc.		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or hear failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between		
- F	Physician/	. 1	Immediate Cause (Final disease or condition Cardio Thrombotic			Onset and Death		
Sant.	Medical Examiner		resulting in death) Due to (or as a consequence of):	cardiovascular d	صادما ا			
	A. Letter	e	Sequentially list conditions.	CAPATOVASCULAR A	1 otel 1			
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury					
	be executed sician and burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):					
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Box 6876(rtifica ling ph	₩	IF FEMALE: 23b. Was decoded program: 23c. If yes, outcome of pregnancy					
) XO	ath ce attenc for us	cian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year		
B	he de y the a	hysi	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown					
s, P.O.	Attending Physician: The law requires that the death certificate be street and the street of the attending physici expert. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?		
oro	w requ	plete			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
Rec	The lar	E O			perform	ed?/ death?		
tall	sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)			
Ϋ́	Physic this c	₽ .	1 Yes 2 No 1 Inpatient 2 EP/Outpat 27. Manner of Death 28a. Date of injury 28b. Time			ce 6 Other (Specify)		
n o	ding l	cate	1 ✓ Natural 5 ☐ Pending (Month, Day, Year) injury		28d. Describe how	injury occurred		
Division of Vital Records,	To the Hospital or Attending Physician: "In thin 24 hours after death as a feet death or To the Funeral Director. After this certification of the Funeral director, and the funeral director director directors are director directors.	Certificate:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Place of Injury - At home, farm, se building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)		
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in	Medical	29a. Certifier (Check check only one) 1 Certifying Physician: To the best of my knowledge, deat of the check only one) 2 Medical Examiner: On the basis of examination and/or involved only one)	estigation, in my opinion, death occurred a	at the time, date and	place, and due to the cause(s) and manner stated.		
	To th within To the comp			29c. License number	29	d. Date signed (Month, Day, Year)		
			29b. Signature and title of certifier MS Ruy apalmse M.D.	D005740		10176/11		
	10,		30. Name and address of person who completed cause of death (Item 23a) (Type V S · Ray a PA V St / M · D · 7835 Sm /	• • • • • • • • • • • • • • • • • • • •	Baltin	10LE MD 7 1269.		
	Stat Registra	· -	31. Date filed (Month, Day, Year) OCT 2 8 2011 Thegistrar's Signature	ales				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 25 OCTOBER 2011 01:44P M FISHBONE RONNI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ATRIUM VILLAGE ASSISTED LIVING OWINGS MILLS BALTIMORE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) **Director** 212-26-8413 1 □ M 2 🔀 F 81 02/01/1930 NYUsual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 203 OLD CROSSING DRIVE 21208 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) DECORATOR RESIDENTIAL event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o epartment of Health and Menta reportment of Health and Menta reportant: If tem 27 is marked any injury or other traumatic and injury or other traumatic and in e. ၉ JOHN GALPERIN ANNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OLD CROSSING DRIVE, PIKESVILLE, MD 21208 IRVIN FISHBONE/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/27/2011 FINKSBURG, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death been signed by the a should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 24 hours after death. Funeral Director: After this certificate Yes 2 No the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 힏 2 👿 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

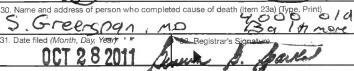
within 2

State Registrar

Greenspan Date filed (Month, Day, Year) 8 201

3 29b. Signature and title of cer

only one



Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0068525

RO

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 Month PAUL WILLIAM GORAY, SR. 25 2011 10:45 PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 912 Dogwood Rd Arundel Glen Burnie Anne Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1.**⊠** M 2 □ F Days 0 1 2 9 1 9 4 6 65 212 44 9001 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1 Tyes 2 X No Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 912 Dogwood Rd 21060 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian Black White etc 1 Never Married 2 Married 2 X No 1 ☐ Yes If Yes, Give 1 ☐ Yes 2.X No Specify. 3 ☐ Widowed 4 ☒ Divorced Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Self Employed Tavern Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Jacob Goray Esther Melva Enos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Goray - former wife 912 Dogwood Rd Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Crematen to Rehmarintstate cemetery, crematory or other place, 4 ☐ Donation 5 X Other (Specify) 10/28/11 Cedar Hill Cem Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) e to (or as a consequence of)

Physician/ Medical Examiner

sician and burial-transit

been signed by the attending physician should be detached for use as the buria

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law

After this certificate has

within 24 hours after death. To the Funeral Director. A

Physician/

Medical

Examiner

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Director

ms 23a or 28a-f show must be notified at

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Health and Mental Hygiene. em 27 is marked other than "natur ther traumatic event, the Medical

item 2

Department of H Important: If ite any injury or oth

Funeral Director

Completed by

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Examiner ျှ Medical Certificate:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): d.	er -		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		opic pregnancy ner (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions cor	ntributing to death but not resulting in the underl	lying cause given in Part I.		o use contribute to the cause of death?
			24a. Was an autopsy performed' 1 \square Yes 2	
25. Was case referred to medical examiner?	lospital:	26. Place of Death (Che		
27. Manner of De th 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 ER/Outpatient 3 28a. Date of injury	28c. Injury at work?	1 dome 5 Residence 28d. Describe how inj	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, tte)
(Check 2 Medical Examine	cian: To the best of my knowledge, death occur er: On the basis of examination and/or investigation Practioner: To the best of my knowledge, death	on, in my opinion, death occurred	at the time, date and pla	ce, and due to the cause(s) and manner stated.
29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, Day, Year)
Manay	- M-D	D39505	Oc	tober 26, 2011
30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Print) Auxan 305 flosh	ital Dr, Glen	Burnie	, MD 21061

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2011 6:39 Рм CAROLYN LOU GRIFFIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth Noc 23, 1947 g. Birthplace (State or Foreign Country) unk If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 🂢 F Hours **Director** 63 291-50-0111 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Frederick MD Braddock Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21714 6012 Jefferson Blvd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. white "natural", Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation unk unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the unk unk Be Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumany. unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 W. 7th Street Frederick, MDFrederick Memorial Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🗓 Other (Specify) ure of Funeral Servic Licensee Wade Startend Affattoff Board 655 W. Baltimore Street mi 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between Sepsis Opset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Adenocarcinama of the Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical se as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ The law requires 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title of certifier

el 2

Tane

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aua

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

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32. Registrar's Signature

29c. License number

M 51610

29d. Date signed (Month, Day, Year)

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21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ 101	tate of Marylan	•			Mental Hyg	giene	
			State Registrar		Cer	tificate of D	Death		Reg. No. 2 0	11,34423
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	26 pay 201	3. Time of Death
· white	Medic	al	ANTHONY L 4a. Facility Name (if not institution, give street			4b. City. Town, or	Location of Dea		4c. County o	
1	Examin	er	4610 FURLEY AVENUE	and marrisory		Baltimo		ALIT	4c. Oddity o	N/A
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 H) Vearl	Birthplace (State or Foreign Country)
	Director		217-24-6807 1 XM	83	Yrs.	World Days	Trodis IVIII	JULY 6	1928	MARYLAND
	ind show at		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	cation				10d. Inside City Limits
	Aaryla 8a-f s tified	Director	MD.			BALTIMO	RE			1 X Yes 2 ☐ No
	a or 2 be no		10e. Street and Number			10f. Zip Code			109. Citizen of WI	hat Country?
	h with	Funeral	4610 FURLEY AVENUE				21206		USA	
	r deat or iten iner i		A	/as Decedent Ever in U.S	S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		- American Indian, s, White, etc.
990	s after ral", c	d by	o Duri La Dei I		1	☐ Yes 2 🗓 No	Specify:		Specify:	WHITE
2	hour hatur dical	Completed	15. Decedent's Education (Specify only highest grade co	on		lent's Usual Occupa		orkina	16b. Kind of Bus	siness Industry
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lan	should be file and Mental I is marked c aumatic eve	ပ	FRANK GARGIULO					SA BALSAN		
ary	thould and M is ma		19a. Informant's Name/Relationship (Type, Pr	int)	19b. Mailir	ng Address (Street a	and Number or l	Rural Route Number		
Σ	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		VINCENT S. GARGIU			2928 COMM	UNITY D	RIVE MI		VER, MD. 21220
			20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Remo	oval from State	emetery, cren	sition (Name of natory or other place		Date		City or Town, State
Ξį	# P 2 %		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	MOS'	T HOLY	REDEEMER	t 10-	31-2011	BALTIMOI	RE.MD. Home, Inc.
Ba	permi Depar Impo any ir once.		Bur Gill	21						yland 21236
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the death	n. Do not ente	er the mode of dying	g, such as cardi	ac or respiratory arr	est,	Approximate Interval Between
F	h_sician/		Immediate Cause (Final	ASCUD						Onset and Death
-	Medical Examiner	П	resulting in death)	Due to (or as a consequ	ence of):					V
н		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ience off:					- year
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	death certificate be executed ne attending physician and ed for use as the burial-transit	EX	that initiated events c. — resulting in death) Last	Due to (or as a consequ	uence of):				-	
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387	rtifica ling pl e as tl	I OU I	IF FEMALE:		201					
Box 687	eath certifica attending p	cian	in the past 12 months?	yes, outcome of pregna Live Birth 2 Feta Pregnant at time of c	ıldeath 3 □	Ectopic pregnanc Other (specify)	y		23d. Date Mon	e of delivery hth Day Year
Ö.	requires that the der been signed by the a should be detached	Physician/M		Unknown	Journ J L					
P.O.	that the ned by details		Part II. Other significant conditions contribu	iting to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contrib	bute to the cause of death?
ds,	quires en sig ruld ba	ted t	Demembrai					_ 1 🗆 `	Yes 2 ☐ No	3 Probably 4 Unknown
COL	aw rec as be	Completed by	Paripheral Viscolon	Diaesce				24a. Was a	sy pr	lere autopsy findings available rior to completion of cause of
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ta	ician: certifi rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospi	tal:		Othe	ace of Death (Co			
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ou o	ading ath. r: Afte	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 🗌 No			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. Of the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	Be. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
Ö	pital c		29a. Certifier 1 Certifying Physician:	To the book of my beauty		and at the time	date and place	and due to the go	ico(a) and mannel	r as stated
	e Hos 124 ho E Fun leted	Medical	(Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	n the basis of examination	and/or invest	tigation, in my opinio	on, death occurre	ed at the time, date a	nd place, and due	to the cause(s) and manner stated.
	To the Hospital within 24 hours a To the Funeral C completed filled	2	29b. Signature and title of certifier		,omougo, t	29c. License			29d. Date signed	(Month, Day, Year)
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	O V .		30. Name and address of person who comple	- A .	23a) (Type, F		re Ban	A ~ ~	2134	
	Sta	to.	31. Date filed Month, Day, Year)	32 legistrar's Signal	lura-		سرده ا	+ ~~	2126	
	Registra		OCT 2 8 2011	Down ,	8. As	erkel				

ANTHONY GARGIULO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER GOODMAN Physician 5:03 AM LEONART 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE FUTURE CARE OLD COURT RANDALLSTOWN Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 77 02/17/1934 MD 219-32-7223 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City. Town or Location r 28a-f show notified at 10a. State 1 ☐ Yes 2 X No Director **RANDALL STOWN** BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or USA 8503 GLEN MICHAEL LANE, APT. 212 21133 or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or item edical Examiner r 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify þ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) UNK traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n SOCIAL SECURITY College (1-4or 5+) Elementary/Secondary (0-12) ADMINSTRATION CLAIMS EXAMINER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 5412 OLD COURT ROAD, RANDALLSTOWN, MD FUTURE CARE OLD COURT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD VETERANS CEMETERY 11/02/2011 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) artery ORONARY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and, bearing to influence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician pe Physician/Medical the use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> HUBERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed FAILURE RENAL 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performed? Yes 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of or Attending 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) HYSICI AN

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature at

30. Name and

OCT 28

of certifier

who completed cause of death (Item 23a) (Type, Print) SUITE 101 M HARISH 541 5 OLD COURT 5415 OLD COURTROAD 32. Pogistrar's Signature

2011

MD 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 2011 2308 Physician/ NDLE ONSTANCE Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) COUNTY OF DEATH
ANNE ARUNDEL **Examiner** HARWOOD MANDRIN CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 1 M 2 M DEC Base MARYLAND 1936 74 Yrs 226-48-1861 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits at 10a, State 10b. County within 72 hours after death with the Maryland Director must be notified 1 🔀 Yes 2 🗌 No PRINCE GEORGE'S MILLERVILLE MD 10g. Citizen of What Country? ö 10e. Street and Number 10f. Zip Code items 23a Funeral 21108 USA 530 VALLEYWOOD ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nonce. GOVERNMENT CLERK 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SALLY BEATRICE RICHARDSON permit. Page 1 and 2 should be GEORGE H. SHEPHARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 530 VALLEYWOOD ROAD MILLERVILLE, MARYLAND 21108 RENE WALLACE/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🎇 Burial 2 □ Cremation 3 □ Removal from State JEFFERSON LANDING CEM 10-28-11 POWHATAN, VIRGINIA 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and -transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Day Month Pregnant at time of death signed by the a Id be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown as been signal by 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 page certificate | 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be MANDRIN 2 No 1 Yes ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After this completed filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1-Natural 5 Pending work' 1 🗆 Yes 2 🗀 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL N

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

OCT 28

. Registrar's Signat

11-07935 Brandon Harvell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | 3 4 4 2 6

		1- For State Registrar	Ce	rtificate c	f Death		Reg	g. No.	
Physici edical Exami		1. Decedent's Name (First, Middle,La Brandon	Harve	e11			Date of Death Month October 21	Day Year	3. Time of Death 2257 hrs
		4a. Facility Name (if not institution, g Peninsula Regional Medi			4b. City, Town, o Salisbury	r Location of Dea	th	4c. County of Dea Wicomico	th
Funeral Director			Sex 7. Age (In yrs. I	ast birthday) Yr	If Under 1 Year Months Day			-90 C	
re, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Filealth and Montal Hygine Montal Hygine file and a file a file and a file a file and a file	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number 2616 Pelham 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce 15. Decedent's Education (Specify Elementary/Secondary (0-12) 9 th Grade 17. Father's Name (First, Middle, Las Wallace 19a. Informant's Name/Relationship Yolanda Harve 20a. Method of Disposition 1 X Burial 2 Cremation 3	AVENUE 10c. City, Ba AVENUE 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No ad If Yes, Give Year or Dates: only highest grade completed) College (1-4 or 5+) NA St) Brown (Type, Print) 211 - Mother Removal from State	.S. 13. W If 1	as Decedent of Hi Yes, specify Cuba Yes 2 No Note that the specified of t	spanic Origin? (\$ n, Mexican, Puerlo specify: attion (Give kind of b. DO NOT use re 18.Mother's Nam Yoland et and Number or am Aven smetery,	Specify Yes or No- oo Rican, etc.) work done tired) we (First, Middle, Middl	g. Citizen of What Could LSA 14. Race - Ame White, etc. Ame Specify: Ame 16b. Kind of Business Recreatialden Surname) Harvor, City or Town, Stationere, M. 20c. Location - City of Lo	nountry) MD 10d. Inside City Limits 1 Yes 2 No Intry? Incoming Black, Incom
Baltimore, permit. Pages I and Department of Heal Important: If item		4 Donation 5 Other Specification of Funeral Service Lice 21 Signature of Funeral Service Lice 23a. Part I. Enter the disease, or com-	y. ensee	~ 22. 6.3	Name and Addres	s of Facility W	ylie Fu Street B	neral Ho Baltimore	
∖/Medical ≞xaminer	Examiner		Biventricular Due to (or as a consequence of the co	hypert: f): f):					
O. Box 68760, at the death certificate be executed by the attending physician and lached for use as the burial - transit	Physician/Medical	W UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow Part II. Other significant conditions	9 OUNIOWII	nancy 2 F eath 5 C	etal death 3	Ectopic pregr		23d. Date of delive	Day Year
Division of Vital Records, P.O. Box 68: In or Attending Physician: The law requires that the death certificate death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as it.	e Completed by	25. Was case referred to medical			26.Plac	e of Death (Check	24a. Was ar autops perform 1 Yes 2	n 24b. Were a prior to ned? death?	
	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Accident Pending 2 Accident Investigat	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	ER/Outpatier 28b. Time of	Injury 28c. Inju	Other ₄ Nursury at Work? Yes 2 No		Residence 6 Othow injury occurred	er.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could no determin 4 Homicide 29a. Certifier	t be ed 28e. Place of Injury - At he (Specify)		-		or Town, Sta	ate)	tural Route Number, City
To the B within 24 To the F complete	Medical	one) 2 Medical Examina 29b. Signature and title of certifier	clan: To the best of my knowled er:On the basis of examination a and manner stated.	ge, death occu ind/or investiga	ation, in my opinio	n, death occurred	at the time, date a	nd place, and due to the 29d. Date signed (M	he cause(s)
		30. Name and address of person who		-		M.E. 00%	I	October 22, 20	11
S: Regis	tate		32. Registrar's Signatu		900 W. Baltin	more Street, I	Baltimore, MD	21223	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34427 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death october 23, 2011 Physician/ 5:00 A M Edward Jacob Horn Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F July I, Pennsylvania 1922 89 Director 220-30-3570 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Bel Air Maryland | Harford 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral items 23a USA 21014 525 Robinson Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 XNo Specify: If Yes, Give Specify: White "natural", Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 8 Foreman permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: if item 27 is marked other any injury or other traumatic event, tt. once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Belle Angela Stine Elmer Edward Horn Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 1120 Poplar Grove Road, Street, Maryland 21154 Sharon Pennington/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Removal from State Bel Air Memorial Gdn 10-26-2011 Bel Air, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Probable acute cerebrovascular accident Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine severe aortic sten that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Attending Physician: The law requires that Completed by hyperlipidemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Division of 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural within 24 hours after death.

To the Funeral Director: After 5 Pending 🗋 Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Continuing Nurse Practioner: To the cest of my knowledge due to the fine, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Drive Bei Air, mo 21014

Registrar

State

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year HAUS 10.40 AM NORMAN 24 2011 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Levindale Geriatric Center Baltimore If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Social Security Number 6. Sex 2-4-1929 Maryland 216-20-2016 82 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 👿 No BelAir Md. Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 4 W. Riding Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1♥ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Maritime Shiprunner 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Zygaj John Haus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BelAir, Md. 21014 Kristine T.Zittle DTR. 4 W. Riding Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Parkwood Cemetery 10-27,2011 Parkville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. Nottingham, Md. 21236 9705 Belair Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MILURE ONGEST Due to (or as a consequence of): ORENARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown EMENTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 40 24a. Was an

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-traneit

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

show r 28a-f show notified at

d other than "natural", or items 23a or event, the Medical Examiner must be

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me

72 hours after

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Be Completed 25. Was Medical Certification: To 27. Mani

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that initiated events resulting in death) Last	C
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. autopsy 2 No

case referred to m	nedical				26. Place of Dea	th (Check only one)		
niner? ∕es 2⊒1√lo	_	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3[DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
	Pending Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c.	. Injury at Work? 1 ∐ Yes 2 ∐ No	28d. Describe how injury occurred		
	Could not be determined	28e. Place of injury - At ho building, etc. (Specif	ome, farm, street, fa	ctory, o	ffice	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

1		13	1							
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.										
	20h Signature an	ad title of certifier	29c, License number	29d. Date signed (Month, Day, Year)						

29b.	Signat	ure and	title	of ce	ertifier
		51			711

31. Date filed (Month, Day, Year) 0CT 28

100645

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE BABATINDE AJANI M) 2434 W.BEWEDERE GERMATRIC 2434 W. BEWESTRE FramE BAZTIMONE MD 21215

State Registrar

PHYSICIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER EUJURIA 20 2011 8:02P M В. **JACKSON** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, FEB. 27 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛭 Min. 1931 **Director** 579-42-8299 80 Yrs. WASHINGTON, DC Usual Residence of Deceden 28a-f show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Directo 1 Yes 2 No MDPRINCE GEORGE'S FORESTVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1421 FERNHILL COURT 20747 USA r than "natural", or items the Medical Examiner mu filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No BLACK Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12TH CLERICA GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be HERBERT LAMONT ETHEL REAVER ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a JAMES JACKSON JR./HUSBAND 1421 FERNHILL COURT FORESTVILLE, MARYLAND 20747 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important; If it any injury or o 1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 11/1/2011 CHELTENHAM, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Reere 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or hear tailure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death P_{III} sician/ FATA L disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to for as a consequence on if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the t IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2₺ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ည 1 Inpatient 2 FR/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 24, 2011 D63688 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR. CHEVERLY, MB. 20785

Registrar

State

DAVIS

31. Date filed (Month, Day, Year)

3001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:00A M 2011 Milburn Ray Jones October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min 220-96-2582 XX_{M2DF} 46 **Director** Maryland April 15,1965 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director Maryland Baltimore 28a-f 1 X Yes 2 No N/A 10f. Zip Code 10g. Citizen of What Country? r must be n 10e Street and Numbe Funeral 3117 Harview Avenue 21234 United States of America items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married filed within 72 hours after Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural" 3 N Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Corvette if Hygiene. life DO NOT use retired Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Performance Center the Mechanic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Margie Sue Jones Jimmy Ray Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3117 Harview Ave., Parkville, MD 21234 Margie Sue Jones-Mother 20a. Method of Disposition
1 ☐ Burial 24X remation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evans Funeral Charella Cremation Services Forest Hill, MD 27,201 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility Evans Funeral Chapel & Cremetion Services — 1 8800 Harford Road, Parkville, Maryland 21234 - Parkville X. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 4RONIC OBSTRUCTIVE PULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of). the burial-tran and Due to (or as a consequence of): attending physician Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No į Month 5 Other (specify) Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy has filled in by the funeral director, page 2 24 hours after death. Funeral Director: After this certificate I 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) OSPICE 1 ☐ Yes 2 ☐ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending iniurv 1 Natural Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

within To the 2

the the

> State Registrar

29a. Certifier

(Check

only one)

3 🗆

29b. Signature and title of certifier

30. Name and address of person when

8

DHMH 17 Rev 06-2011

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr g920 10-28-11 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month Anthony Eugene Johnson 0153 PM 201 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death ST AGNES HOSPITAL BALTIMORE 5. Social Security Number 6. Sex If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ▼ M 2 □ F Months Days Hours Min 3-24-194 Year 218-44-1907 64 MD Director Usual Residence of Deceden free 73 is marked other than 'natural', or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 X Yes 2 ☐ No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 USA 14 N. Gilmor Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 ☐ Never Married 2 🄀 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Il Hygiene. other than "natural", Specify: African-American 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Truck Driver Construction Company Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy important: If item 27 is marked oth any injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Allen Lee Lillian Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Matthews/sister <u>1114 Kevin Road, Baltimore, MD 21229</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 10-27-2011 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wile Fineral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Necroti sing disease or condition week Medical resulting in death) **Examiner** urknown Markid obe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a nonsequence or, attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 1 Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Sulcide
4 Homicide Investigation
6 Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one 29b. Signature and title of certifier 29c. License number Meenakshi, Resident - Physician P-26615 10/22/2011 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Meenakshi

31. Date filed (Month, Day, Year)

ANTHONY

JOHNSON,

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BALTIMORE

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900 S.

32. Registrar's Signature QCT 2 8 2011

			Plea	se Type or									_	ble.			
	State of Maryland / Department of Health and Men 1 - State Registrar Certificate of Death							∕lental Hy	ntal Hygiene								
	Registrar Certificat 1. Decedent's Name (First, Middle, Last)						uncate o	Deau	1	Reg. N			+-+-	3. Time of Death	_		
Physiciai Medic		CHAR	OTT		1014	N90	N				Month	16	20	Year	2:25 pm	1	
Examine	er	4a. Facility Name (if	not institution,	give street and numb	1 (2 1/2)							4c. County of Death BALTIMORE					
° Funeral Director		5. Social Security N		6. Sex 1 □ M 2 X F		yrs. last birtl	hday) Yrs.	If Under 1 Ye Months Da			8. Date of Bir (Month, Da Sept 20	th ay, Year) 19	35		place (State or Foreign htry) yland	n	
nd how at	'n	Usual Residence of 10a. State			10	c. City, Town	or Loc	cation						- 1	10d. Inside City Limits	<u> </u>	
Maryla 28a-f s otified	irect	MD			Baltim										1 X Yes 2 □ N	0	
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	0e. Street and Number 5804 Merville Avenue				10f. Zip Code 21215					10g. Ci	itizen of W US	ntry?				
e it	ğ	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U Armed Forces 2 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.			in U.S.	S. Its Decedent of Hispanic Origin? (Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ★ No Specify:							k, White,	can Indian, etc. ack			
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within 7 giene. er than the M		Elementary/Sec 12	onday (0-12)	College (1-	Gollege (1-4 or 5+)				OTuseretired) foster mother					childcare			
id be filed wental Hygarked oth		17. Father's Name (First, Middle, Last) Benjamin Franklin Johnson 18. Mother's Name (First, Middle, Maiden Sumame) Charlotte Cordelia Pi															
d 2 shouled 2 shouled and a 27 is mer traum.		19a. Informant's Na Edwina		ip <i>(Type, Print)</i> Goines/n:	iece	^{19b} 5	Mailin	g Address (Stre Shale	et and Num Grove	Aven	al Route Numbe ue Balt	er, City oi : imo 1	r Town, St	tate, <i>Zip</i> D 2	.1215		
Page 1 an nent of He ant: If iten ıry or oth			☐ Cremation	3 □ Removal from Specify)	State			sition (Name of natory or other p	olace)		Date	20c. L	ocation -	City or T	own, State		
permit. Departr Import. any Inje		21. Signature of Fu	neral Se vice Li		irec	tor		Name and Add	-		d 655 W	. Ва	1timo	ore	Street		
Physician/ Medical		23a. Pan 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List or (Final	complications that can have one cause on each	th line.	VDB	not ente		ying, such			crest,	AR I	25	Approximate Interval Between Onset and Death	7	
Examiner	Physician/Medical Examiner														UNEWOO	ا ل	
uted nd ransit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.															
ii a e		resulting in death) Last Due to (or as a consequence death)						e of):									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent in the past 12 I 1 ☐ Yes 2 ☐ g ☐ Unknown	months? ☐ No	23c. If yes, outo 1 Live E 4 Pregn 9 Unkno	Birth 2 🗀 ant at tim	Fetal death		Ectopic pregr Other (specify					23d. Dat Mor		very Day Year		
res that the signed by dibe deta	ρ	Part II. Other signif	TOPU	ns contributing to de	ath but no	ot resulting i	n the u	nderlying cause	given in Pa	art I.					the cause of death?	vn	
To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed		DIA	MENITA	, 6	Mirll	c	15			24a. Was auto perfi 1 \(\sum \) Yes	opsy ormed?	, a	rior to co leath?	opsy findings available ompletion of cause of		
cian: T ertifica ector, p	Be Co	25. Was case referre		Hospital:				_	. Place of D	eath (Chec		2 5 00 1V	101	L les	2 🗆 110		
Physi er this o	e: 10	27. Manner of Death	h	28a. Date o	of injury	28b. T	ime of	t 3 □ DOA 28c. Ir	jury at	Nursing H	ome 5 Resi				y)		
tending leath. or: Afte the fun	Certificate:	1 W Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be					injury work? M 1 ☐ Yes 2 ☐ No										
Hospital or Attendi 24 hours after death. Funeral Director: A eted filled in by the fu		4 Homicide	determi	28e. Place							ation (Street and Number or Rural Route Number, or Town, State)						
ne Hospii in 24 hour ne Funera pleted filli	Medical	(Check 2	Medical Ex	Physician: To the be kaminer: On the basis Nurse Practioner: T	s of exami	ination and/o	r invest	igation, in my o	inion, death	n occurred a	at the time, date	and place	e, and due	to the ca	ause(s) and manner sta	ated	
To the I within 2 To the I comple		29b. Signature and	fitle of certifier	= ika	i	MI			nse numbe		2		ate signed	$-\frac{12}{2}$	Pay, Year)		
		30. Name and address	RETH [who completed cause	RG	910	79	上13%	214	ROA	n BAC	Tin	1006	202	MO 2113	3	
State Registra		31. Date filed (Mont	T 2 8 2	011 Sent	gistrar's S	A. A	bar	w									

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHMOUD

31. Date filed (Month, Day, Year,

19

1) 19, Ridy 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011

Birthplace (State or Foreign Country)

white

1050 York Road Towson, MD 21204

Month

Approximate Interval Between Onset and Death

Year

New Jersey

10d. Inside City Limits 1 ☐ Yes 2 ☐ No

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 34434 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KERN OCTOBER Physician/ 2-0/1 6:15 Medical or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Balti rene ledi cal au If Under 1 Year If Under 24 Hrs. 9 Birthplace (State or Foreign 8 Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Min 08 09 1964 Hours 215 86 7209 47 Yrs Director MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2.X No Pasadena MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 21122 8641 Black Rock Harbor U.S.A. items, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 9 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. 27 is marked other than "natural", traumatic event, the Medical Exar 3 Widowed 4 Divorced Specify. White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) filed within al Hygiene. Manufacturing Machinist 10 Department of Health and Mental Hy Important; If item 27 is anxived other any injury or other traumaticance. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nancy-Ruth Harriett Wayland Bernard Edward Kern, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21122 8641 Black Rock Harbor Pasadena, MD Felicity Kern - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory 10/29/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bavview 21. Signature of Franer Pervice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, Pasadena, Drive 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ato cel Mer Carcinerya Physician/ disease or condition resulting in death) Medical a consequence of Examiner Security list nanditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or s a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph I for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death the 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after death. e Funeral Director: After this certificate has autopsy performed Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No iniury Natural 5 Pending Investigation ☐ Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the P only one) 29b. Signature and title of certifie DR. 056390 NAZARIN

DHMH 17 Rev 7/2009

State

Registrar

30. Name

address of persor

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31. Date filed (Month, Day, Year,

Back

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ho completed cause of death (Item 23a) (Type, Print)

				Plea	se Type or							-		-	ible.		
			For State Registrar		State o	f Maryla	nd / Dep <i>Cei</i>		ent of F ate of E		and N	lental Hy	/gieno Reg. N	20	11	34	435
-	Physicia Medi	cal	1. Decedent's Name (Fi		MERVIN		KIT	TREL				2. Date of Death Month Day October 26, 2			Year	3. Time of 3: 20	of Death
	Examin	ner	4a. Facility Name (if not DOCTORS 5. Social Security Numb	HOSPI	TAL		last birthday)	1	ty, Town, or ANHAM der 1 Year			0 D-4 4 Di	P	RINC	E GE	ORGE'S	
	Funeral Director		244-70-88 Usual Residence of Dec	77	1 X M 2 D F	64	Yrs.	Month		Min.	8. Date of Bir APRIL	rth ay, Year) 2 I	947		place (State TH CAR		
	Maryland 28a-f sho	irector		b. County	GEORGE'S		ity, Town or Lo		LE			-				10d. Inside 0	City Limits es 2 □ No
	h with the is 23a or 3	Funeral Director	10e. Street and Number 1400 BAY		TERRACE				Zip Code 0731				10g. C	Citizen of V	/hat Cou	ntry?	-
9800	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho et than Examiner must be notified at	<u>₹</u>	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 🌠	Divorced	If Yes, Give Year or Da	ces? 2 📉 No e	1		edent of Hi ecify Cuba 2 🛣 No			cify Yes or No- Rican, etc.)	-	Blac	4. Race - American Indian, Black, White, etc. specify: BLACK		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed		only highes	's Education t grade completed) College (1-	4 or 5+)	life. D	kind of v	vork done d use retired)		t of workii	ng		Kind of Bu		ndustry	
yland		To Be	17. Father's Name (First JESSE M.		•						er's Name			iden Surname) THAM			
	- 44			ODS/S			1400) BA	YTREE	TERR	ACE	Route Number	er, City o LLVI	LLE, N	tate, Zip IARY	Code) LAND 2	0731
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposit 1 XBurial 2 C C 4 Donation 5 C 21. Signature of Furera	remation 3 ☐ Other (Sp	ecify)	Stato	Place of Dispo cemetery, cren T. LINO	COLN Name	CEME' and Addres	TERY s of Facilit	10/3 y J	oate 1/11 . B. JI AD HYA	BRE ENKI	NTWOO	DD,M. JNER		E, INC
	Physician/ Medical Examiner Bright Hausit	Jical Examiner	23a. Part 1. Spher the days of the shock, or heart tail immediate Cause (Nha disease or condition resulting in death) Sequentially list condition to the shock of the shock o	llure. List on	a. Due to (c	:h line.	quence of:									Approxima Interval Be Onset and UnKa	tween Death
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate bewithing 4 burns after death certificate that burns after death After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burns label.	Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?		irth 2 🗆 Fet ant at time of	al death 3 🗌	Ectopi Other		√	2				23d. Date of delivery Month Day		Year
Division of Vital Records, P.O.	v requires that the death been signed by the atte should be detached for	þ	Part II. Other significan	t condition	s contributing to de	ath but not re	sulting in the u	nderlyin	g cause give	en in Part I						he cause of o	
l Reco	vysician: The law r iis certificate has b director, page 2 sk	Completed	25. Was case referred to	modical								1 🗆 Yes	psy ormed?	p	rior to co eath?	psy findings empletion of 2 🔀 No	
Vita	ysicial s certi directo	To Be	examiner?		Hospital;	natient 2	ER/Outpatien	+ 3 🗀	Otho	ce of Deat		<i>only one)</i> ne 5 □ Resid		. [] out-		,i	
on of	nding Ph ath. : After thi e funeral		27. Manner of Death 1 Natural 5 Accident	Pending	28a. Date o (Month		28b. Time of injury	М	28c. Injury work?	at	2	8d. Describe				/)	
Divisio	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completed filled in by the funeral	al Certificate:	3 Suicide 6 4 Homicide	Could no determine	28e. Place o	of Injury - At he	ome, farm, stre	et, facto	ry, office		2	8f. Location (S City or Tou			r or Rura	l Route Num.	ber,
	the Hosp hin 24 hou the Funer mpleted fil	Medical	(Check 2 Nonly one) 3 (Check	Medical Exa Certifying N	hysician: To the be iminer: On the basis urse Practioner: To	of examinatio	n and/or invest	igation, i	n my opinior	 death oc 	curred at t	the time, date a	and place	e, and due	to the ca	use(s) and ma	anner stated
			29b. Signature and title of	to R	~				n DD	43	446		10	ate signed	111		
	19		30. Name and address o	Fara	ni-Far,	of death (Iten	23a) (Type, P	rint)	dloes	sPro.	mi5	e Dr.,	Boi	310	mo	. 20	120
	Stat Registra	e ır	31. Date filed (Month, Da	28 20	11 Cent	gistrar's Signa	ure par	les!				,		- (-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene
			Registrar Certificate of Death Reg. No. U 1 3 4 4 3 0
	Physicia	an/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year
	Medi		William Arthur Koegel Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Examir	ier	4a. Facility Name (if not institution, give street and number) SAINT JOSEPH MEDICAL CENTER 4b. City, Town, or Location of Death TOWSON 4c. County of Death BALTIMORE
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
b	Director		220-30-5948 1 M 2 D F Months Days Hours Min. (Month, Day, Year)
	nd how at	٦	Codd Residence of Decedent
	laryla 3a-f s iffied	Director	Maryland Harford Forest Hill 1 ☐ Yes 2 ⅓ No
	the N or 2	٥	Maryland Harford Forest Hill 1 Yes 2 X No
	s 23a sust b	Funeral	308 Willrich Circle Unit K 21050 USA
	death item		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
36	after II", or xami	dby	1 □ Never Married 2 LA Married 1 □ Yes 2 X No If Yes, Give 1 □ Yes 2 X No Specify:
00	nours atura ical E	Completed	15 Decedant's Education
215	n 72 l e. ian "r Med	dmo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Ibl. Business/Industry 16b. Kind of Business/Industry
21	withi /gien≀ nerth t,the		2 Telephone Repairman Communications
nd	e filed Ital Hy ed ott	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
3	uld bud Mer marke		William Arthur Koegel Sr. Anne Elizabeth Luber
Maryland 21215-0036	2 sho tth and 27 is i traur	- 0	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Willrich Circle, Unit K. Forest Hill, MD 21050
ē,	f and f Heal item		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
alti	permit. F Departm Importa any inju		Det Air Melloriar Guille 11-4-11 Det Air, Maryland
<u>m</u>	8 8 5 6 8		21. Snature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014
			23a. Part 1, Epter the visease, or complications that caused the death. Do not enter the mode of dvino, such as cardiac or respiratory arrest
-	Physician/		Immediate Cause (Final SEPSIS Onset and Death disease or condition
	Medical Examiner		resulting in death) Due to (or as a consequence of): LID TNA DV PD A CHI TNAD CHITCON
		er	Sequentially list conditions, if any, leading to intrincipate URINARY TRACT INFECTION Due to (or as a consequence oi):
O.	ted I Insit	mim	cause. Enter Underlying Cause (Disease or injury
) 0	execu in and ial-tra	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of):
Box 68760 K	cate be executed physician and s the burial-transit	dical Examiner	d
87		Med	IF FEMALE:
× 6	ss that the death certifications by the attending is be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1
Box	the a	ıysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Month Day Year 9 ☐ Unknown
P.O.	requires that the been signed by the should be detach	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Š,	uires t n sign uld be	g pe	RESPIRATORY FAILURE
orc		plet	24a. Was an 24b. Were autopsy findings available
Vital Records,	The law ate has page 2 s	Completed by	autopsy prior to completion of cause of performed? death? 1 □ Yes 2 □ No
e	ian: Tian: T		25. Was case referred to medical examiner? 26. Place of Death (Check only one)
5	hysic his ce al dire	၉	1 Yes 2 X No
Division of	ling P	Certificate:	27. Manner of Death 1 X Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28d. Describe how injury occurred work?
SIO	I or Attendi after death Director: A d in by the f	tific	2 Accident Investigation 3 Suicide 6 Could not be
Ĕ	lor A after Direction by		4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
_1 ,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
:	the Hk lin 24 he Fu ipletel	≥	only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
- 1	Vith Vith Con To to		29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
	_		D24034 10/27/2011
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW, M. D. 7601, OSLEB, DRIVE, HOWGON, M. D. 2400.
	State		TIMOTHY LOW, M.D. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year) 2. Registrar's Signature
	Registra	_	OCT 2 8 2011 Control of the control
		_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert J. Kaufmann 25,2011 Medical October 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3901 Darleigh Road Unit Nottingham Balto. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** . Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Director 219-28-6110 Usual Residence of Deced 1 😿 M 2 🗆 F Maryland 78 May 1,1933 show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Md. Balto. 1 Tes 2 XNo Nottingham 10e. Street and Number 9 10f. Zip Code ral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral 3901 Darleigh Road 21236 Unit USA death . 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 X Yes : 2 No filed within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify. "natural" White Completed 3 Divorced Year or Dates Medical 15, Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Manager Printing Company other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joseph Kaufmann Catherine Schwarz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 s of Health If item 27 Unit 3A Marian M. Kaufmann Spouse 3901 Darleigh Road Nottingham, Md.21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department c Important: If any injury or ö Gardens of Faith 10-28-2011 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. Shamuen 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Due to (or as consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and -tran that initiated events resulting in death) Last Due to (or as a consequence of): burial physician s the burial Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Fetal death
Pregnant at time of death ξ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 page this certificate funeral s after death. the filled in by 24 hours a

Be

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Certificate:

Medical

autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 00 1 Inpatient 2 I ER/Outpatient 3 I DOA

4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N32543

21093

NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

completely

To the P within 2. To the P

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} **2 4** OCTOBER Н. Kauffman, Jr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 X M 2 🗆 01/24/1948 Director 178-40-7666 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location the Maryland Director notified 28a-f MD N/A Baltimore 10e. Street and Number ò 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 2819 Goodwood Road Apt. 21214 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. þ 1 X Never Married 2 Married ☐ Yes 2 X No 3altimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Culinary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kauffman, Sr. Margaret 19a. Informant's Name/Relationship (Type, Print) Nancy J. Sherman, Sister 4607 West Landis Lane, Glendale, AZ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Mary's Church Cemetery: 10/28/2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ pontaneous disease or condition resulting in death) Medical Due o (or as a consequence of): **Examiner** Sequentially list conditions. in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of). physician Physician/Medical death certificate be Box 68760 as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ed by the a detached f 1 Yes 2 L 9 Unknown 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Division of Vital Records, 1 Yes 24a. Was an sate has page 2 autopsy Hospital or Attending Physician: The 124 hours after death.
Funeral Director: After this certificate heted filled in by the funeral director, page performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: pital; 1 inpatient 28a. Date of injury 1 Yes 2 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28b Time of 28c. Injury at work? Natural (Month, Day, Year) 5 \square Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide n 24 hours after de re Funeral Directo pleted filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 🖒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 101 535

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85306 20c. Location - City or Town, State Lancaster, PA Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) **ORIGINAL**

2011

Black, White, etc

2:33

Birthplace (State or Foreign Country)

White

Flosser

PA

1 Yes 2 No

10d. Inside City Limits

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 21 per dvr.,g920_10/28/2011dhb,
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year (ansing John William 6:50 A M 1105 Medical 10 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles how n Care Center 21228 Baltimere, Md Baltimere Social Security Number 7. Age (In yrs. last birthday) Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Hours Min (Month, Day, Year) Oct. 30,1931 525-62-9011 79 Director Delaware Oct. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD **Baltimore** Catonsville 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 715 Maiden Choice Lane CR403 USA n "natural", or item Aedical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 No 1955 1 Never Married 2 Married Black, White, etc. ð Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 1957 Completed 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **5+** University Professor College 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve ည Pearl Elizabeth Jones William Dwight Lansing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Lansing/spouse 715 Maiden Choice Lane CR403, Catonsville, MD 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) per DVR Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board, Ronald S. Wade, Director 655 W. Baltimore Street, Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Atherosclerotic cardiovasular disease disease or condition resulting in death) Medical Examiner Mellitus Type I Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner signed by the attending physician and de detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ rtension with chronic Kidney 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Vascular demention 24a, Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 20 Z No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral dii Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medica 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) In M. Buttowort CRNP 10-10-2011 R092382 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Ann M. Butterworth

2 8 2011

31. Date filed (Month, Day, Year)

Maidenthice lane Baltmere

Md 21228

709

CRNP

32.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#11perINF, 6936, 27872013, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Denis 9:40 A M Alan October Le Cam 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) 1**X**XM 2 □ F Days Hours Min. Country) California **Director** 58 546-74-6005 Ĩ952 Nov. Usual Residence of Decedent 10a. State with the Maryland 10b County Director 10c. City, Town or Location 10d. Inside City Limits notified 28a-f DC Washington D.C. 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 4607 Connecticut Ave. NW 20008 United States items Page 1 and 2 should be filed within 72 hours after death "natural", or iten edical Examiner r 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4-XDivorced Specify White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Dept. of Labor Stats. Elementary/Seconday (0-12) Hygiene. College (1-4 or 5+) Computer System Analyst Federal Government of Health and Mental Hygie f item 27 is marked other r other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lucien Le Cam Μ. Romig Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. 3775 Modoc Rd. #138, Santa Barbara, CA Louise Le Cam / Mother 93105-4458 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 10/27/2011 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signa mae Licensee 22. Name and Address of Facility d Kapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final SEPSIC Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** NEUMONIA Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) -transit and 15 0940 RM 1016 Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Pinpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 1 Yes 2 No within 24 hours after deat To the Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 320, MU 00057114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar DOA

RAUNG

OCT 28

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32. Registrar's Signature

11-07964
Vincent Lipira

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month **Medical Examiner** 0910 hrs Vincent LiPira October 23, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Min Country Maryland 1 X M 2 F 50 Yrs July 30, 1961 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sho 1 Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho Baltimore Catonsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6206 Chesworth Road USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 2 X No Yes 3 Widowed 4 X Divorced If Yes, Give Yeer 1 Yes 2 X No specify: White ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 4 Mortgage Broker Finance 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Salvatore LiPira Rosina DiFatta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosina LiPira Mother 6202 Chesworth Road; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Lake View Mem. Park 10/27/2011 4 Donation 5 Other Specify:(Sykesville, MD 22 Name and Address of Facility Sterling Ashton Schwab Witzke Signature of Funeral Service Licentee Funeral Home of Catonsville, Inc 11630 Edmondson Avenue: Catonsville
23a. Part I. Enter the disease, or somplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Hypertensive Athersclerotic Cardiovascular Disease Immediate Cause (Final disease) *≛*xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any leading to immediate Directo (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical attending physician or use as the burial • X UNPENDED \square AMENDED 23a, pt. II, 27, per me, g923 1-9-12 sm The law requires that the death certificate be Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown Chronic Alcohol Abuse; Obesity Completed 24a, Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of performed? death? certificate page ✔ Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ Nursing Home 5 Residence 6 Other: this 2 1 🗸 Yes 2 No neral Director: After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural · death. 1 Yes 2 No 2 Accident Investigation within 24 hours after d

To the Funeral Direct
completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 4 ___ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 24, 2011 Lassell 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD

State Registrar

OGME

31. Date filed (Month, Day, Year)



Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year prothu 2011 :45 PM Medical 4a. Facility Name (if not inelitution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's

poial Security Number 6. Sex Prince George's Hospital Cheverly 7. Age (In yrs. last birthdav) If Under If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 Year 8. Date of Birth Month, Day, Yei une 10, 1 □ M 2 👿 F Months Days Hours Min 441-30-5028 0klahoma **Director** Yrs 80 1931 June Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 🗆 Yes 2 😾 No Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 M Ridge Road 20770 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Amos Woods Fanny Frey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexa Lauber/daughter 9 M Ridge Road Greenbelt, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 X Donation 5 Other (Specify) Ronal of Puneral Service ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street MD 21201 rt 1. Enter the disease, or complications that caused the death. Donot enter the dying, such as candiac or Approximate or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjuly and the burial-tran that initiated events resulting in death) Last Due to (or consequence of physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death the a Unknown g 9 Unknow s been signed by the should be detach Part II. Other significant conditions contributing to death but not result 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has b lirector, page 2 sl autopsy perforn death? 1 ☐ Yes 2 ☐ No Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Tes 1 Nnpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending within 24 hours a er death.

To the Funeral Director A completed filled i by the fu Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of orni 29c. License number 29d. Date signed (Month, Day, Yea 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signatur

3001 Hospital Drive Cheverly, MD 20785

Demetrois James Catevenis

31. Date filed (Month, Day, Year)

OCT 28 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a, per phy, g921 11-9-11 sm State of Maryland 7 Department of Health and Mental Hygiene 2 1 34443 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Physician/ Lee 2011 05:00A D. Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Hart Heritage Assisted Living Forest Hill Birthplace (State or Foreign Country) . Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) Davs Min 220-22-9529 Director 1 🗶 M 2 🗆 F Yrs. 82 MD 12/27/1928 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 X No Perry Hall Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numb Funeral 21128 U.S.A. 4824 East Joppa Road ral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

X Yes 2 No þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1946–48 and Mental Hygiene.
is marked other than "natural", White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanical Design Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Wettstein Maybelle Lee Thomas Department of Health and Important: If item 27 is many injury or other traums 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4824 E. Joppa Road, Perry Hall, MD 21128 Mitchell Lee, Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10/29/2011 Baltimore, MD Parkwood Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Service Licenses 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Pneumonia years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes Il or Attending Physician: after death.
Director: After this certifications 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Medical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALMAN SPANUS 615

W. MARPHAIL RA BUL ANMA - 21014

October 27,2011

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

35889

29c. License number

31. Date filed (Month, Day, Year)

29b. Signature and title of cert

2 | 3 |

28

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October_ Physician/ 26, 10:15 PM Josephine Α. Landes 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 217-07-0904 1 M 2 F **Director** Yrs. March 1, 1914 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore Parkville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3209 Chesley Avenue 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceue...
Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: Completed 3€ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is mark—any injury or com-2 Nicholas Gentile Edna Brown 19a. Informant's Name/Relationship (Type, Print)
Peggy Kaelber/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9608 F Haven Farm Road Perry Hall MD 21128 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Maryland 4 Donation 5 Other (Specify) 10/31/11 Parkwood 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END STAGE CARDIAC DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No
9 Unknown Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 3 Probably 4 Unknown 2 2. No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 👿 No Other: 4 Nursing Home 5 Residence 6 TO Other (Specify) HOSPICE ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

LANDES Box P.O. Records, Division of Vital 24 hours

p-m

State

30. Name and address **JACKIE** JONES,

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year, OCT 28

Registrar

Medical

29a. Certifie

(Check only one 29b. Signature and Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

en M	eith Mills	•	1- For State	tate of Marylar		rtment of tificate of		u ivientai n		g. No. 20	111 34	445	
odic	Physici al Exami	an/	Decedent's Name (First, Midd		ai th	Mil	1.0		2. Date of Deat Month October 2	h	3. Time of Deat 1809 hrs	th	
سلباده	ai Exaiii	illei	4a. Facility Name (if not instituti		eith		LS 4b. City, Town, or	Location of Deat		4c. County of	Death		
			106 East Susquehan		A (1		Baltimore If Under 1 Yea	- I k Hadas Odlia	D Date of Die	Baltimore	9. Birthplace (State or		
	Funeral Director		5. Social Security Number 220-52-2620	6. Sex 7	. Age (In yrs. Ia		Months Day		1.	28,1948	Foreign Country)Mary1		
	any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on				10d. Inside City	y Limits	
	≱ .,,	Ē	Maryland Balt	imore	Т	owson					1 Yes 2	XNo	
	Maryla r 28a-f ed at o	Director	10e. Street and Number				10f. Zip Code		10	og. Citizen of Wha	•		
	ith the	al Di	106 Susquehann	a Avenue	Apt. L		21286		pecity Yes or No-	U.S	American Indian, Blac	*.	
	r items	uneral	1 Never Married 2 N				es, specify Cubar			White,	etc.		
	ral", o	by F		ivorced If Yes, Give Year or Dates:			Yes 2 No		wal dans	Specify:	White		
	2 hours	Completed	 Decedent's Education (Specific Elementary/Secondary (0-12) 				t's Usual Occupa ost of working life			100. Kind of Busi	iness/maustry		
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21215-0036	and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 28s-f show fraumatic event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name (First, Middle H.	e, Last) Allen	Mil1:	c		1B.Mother's Nam Earl:		Maiden Surname)	Thomas		
212	ould be d Ment s mark ic even	To B	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing		et and Number or	Rural Route Num	ber, City or Town,	, State, Zip Code)	21.20	
A	permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is mainjury or other traumatic ev		Hollie Nicole 20a. Method of Disposition	Mills Daug	,		ast Susc	*	Avenue	,	Maryland City or Town, State	2128	
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Ē	nit. Pa artmen oortant ury or o	ð	Donation 5 Other S	ipecify: e L icensee	Boc	nsboro 22. N	Cemeter lame and Address				ro Marylaı ral Home,		
ä	perr Dep Imp		Tanklit	Jagan			50 York	Road T	lowson, l	Maryland	21204		
	nysician Medical		23a. Part I. Enter the disease, o failure. List only one cause	e on each line.					or respiratory arre	est, shock, or hear	t Approximate Between On: Death	set and	
È	xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c			ovascular Dis	sease					
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		edical Examiner	UNPENDED AMENDED										
Box 68760,	ficate be g physici s the buri	-	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, ou			tal death 3	Ectopic pregn	ancv	23d. Date of d Month		ear	
89 X	he death certificate the attending phy hed for use as the l	Physician/N	past 12 months?	4 Pregnar	nt at time of de		her (Specify)				,		
		Phys	Part II. Other significant condi	9 Ulikilow		esulting in the u	inderlying cause	iven in Part I.	23e. Did to	bacco use contrib	oute to the cause of de	ath?	
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οĘ	ding Physi After this funeral dir	: To	1 Yes 2 No 27. Manner of Death	2Ba. Date of (Month, D		2Bb. Time of I		ry at Work?		now injury occurre			
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	Hospital or Attenc 24 hours after death Funeral Director: stely filled in by the		29a. Certifier 1 Certifying F	Physician: To the best of	of my knowledg	ge, death occur	red at the time, d	ate and place, an	d due to the caus	e(s) and manner a	as stated.		
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Ex	aminer: On the basis of and manner sta	examination ar	nd/or investigat	tion, in my opinior	n, death occurred	at the time, date	and place, and du	e to the cause(s)		
	. , , ,	Ž	29b. Signature and title of certif	ier	Da	7	29c. Licens O.C.			29d. Date signed October 26,	ned (Month, Day, Year)		
	/		30. Name and address of perso	n who completed cause	of death (Item	23a)		ITI. L.	· · · - · · · · · · · · · · · · · · · ·	00,000 20,	2011		
	(C)		Patricia Aronica-Polla				900 W. Baltin	more Street,	Baltimore, Mi	D 21223			
		tate trar	31. Date filed (Month, Day, Year OCT 2820	32. Reg	istrar's Signatu	Fam Ha	,	-					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physi Medical Exa			l. Decedent's Name (First, Mide ROBERT EI		AVCK I	R	_]2	2. Date of Dea Month October 1	Day	Year		me of Death 634 hrs
		4	la. Facility Name (if not instituti E/B Powder Mill Road	ion, give street and	d number)				Town, or L	ocation of	Death		4c.	County of De		
Funer Direct		*	5. Social Security Number 214-68-9158	6. Sex		In yrs. la	ast birthday) Yrs	Mont	der 1 Year ths Days	If Under Hours	24Hrs. Min.	8. Date of Bir		For	Birthplac eign WA Country)	SHINGTON
ow any	•a	ľ	Jsual Residence of Decedent 10a. State 10b. County	CE GEORGI			Town or Locat	ion	· · ·							Inside City Limits Yes 2 No
he Maryland or 28a-f show	notified at once		MD PRING Oe. Street and Number 10815 LOBLOLG				LAUKEL		ip Code 0708			1	0g. Citiz	zen of What C	ountry?	
r death wi	must be		11. Marital Status 1 X Never Married 2 N 3 Widowed 4 Di		s 2_	ver in U.S ARMY No	Z If Y	es, spec	dent of Hispolicify Cuban,	Mexican, F		cify Yes or No lican, etc.)		14. Race - An White, etc		
36 iin 72 hours aft han "natural"	the Medical Examine	bleced by	15. Decedent's Education (Spr Elementary/Secondary (0-12) 12th	l or Dates: ecify only highest			16a, Deceder	nt's Usua lost of w	I Occupation	n (Give kii DO NOT u			16b. K	GOVERNA	ss/Industr	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ent, the Me		7. Father's Name (First, Middle ROBERT E. MAC						18			First, Middle, I NE JOH				
MD 21 nd 2 should alth and Me	aumatic cy	1	9a. Informant's Name/Relation MICHELLE P. N			I 20b B	19b. Mailing 15832	BOE	BOLINK	DRI	VE W	ral Route Nun OODBRI	DGE ,	ty or Town, St VIRGI	NIA	22191
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural",	Injury or other tr		1 Burial 2 X Cremation 4 Donation 5 Other Str. Signature of Funeral Service	Specify:	al from State	L C	rematory or ot VERDALE	CRE	e) EMATOR d Address o	RY of Facility	10/2 J.	6/2011 B. JEN	RIV	VERDALI	E,MAF	
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5x 6876 ath certificat attending phy	Physician/Me	23	F FEMALE: Nb. Was decedent pregnant in t past 12 months? Yes 2 No 9 Un	the 1 Liv	es, outcome ve birth egnant at tin nknown		2 Fe	tal death her (Spe		Ectopic p	oregnand	су		i. Date of deliv Month	rery Day	Year
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Vital Vital bysicians	director	$ ^2$	5. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	Inpatient	2 🔲 l	ER/Outpatient	3 🔲 1	26.Place o	44			Reside	nce 6 🗸 Ot	her: Scen	ne
Division of Vital all or Attending Physician rs after death.	ation: T	2	7. Manner of Death 1 Natural 5 Pen	ding 28a. D	ate of Injury onth, Day Year 7, 2011		28b. Time of I 0616 hrs	njury	28c. Injury	at Work?	10 M	8d. Describe I Iotorcyclist	involv	ved in colli		
Division To the Hospital or Attentivitin 24 hours after death To the Funeral Director	Certification:	2	Suicide 6 Cou	ald not be ermined (Spec	^{ify)} Major	Road	me, farm, stree									westofRt19 westofRt19 m, Beltsville, MD
o the Horithin 24	Medical	0	Check only	Physician: To the aminer: On the base and manner	sis of examin											se(s)
	° Š	2	9b. Signature and title of certific	er				29	O.C.M					Date signed (in the contract of the contract o		ay, Year)
8 24		3	0. Name and address of persor Ana Rubio MD. Ass	n who completed o				imore:	Street, B	altimore	e, M D	21223	L			
	State istra	4	1. Date filed (Month, Day, Year)		Registrar's	Signatur	bar	Kel								

11-07802 Timothy Regina	ıld N	tate of maryana, populario	ent of Health and Mental		gible. 2011 3444			
4		Registrar Certifica	te of Death		Reg. No.			
Physici Medical Exam		TIMOTHY REGINALD MURR		2. Date of Dea Month October	Day Year 1741 hrs			
		Facility Name (if not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of Dea Cheverly	ath	4c. County of Death			
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birth)	,	Im I Poto of Pi	Prince George's			
Director		578-94-8913 XM 2 F 48	in. FEB.	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign WASHINGTON Country) DC				
ow any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location		10d. Inside City Limits			
Maryland 28a-f show 1 at once.	ctor	DC WASHIN	GTON 10f. Zip Code		1 X Yes 2 No			
or 28	Funeral Director	60/ HADYADD CEDEET N. I.			log. Citizen of What Country?			
with the 23a	<u></u>	604 HARVARD STREET N.W. 11. Marital Status 12. Was Decedent Ever in U.S.	20001 13. Was Decedent of Hispanic Origin? (Specify Ves or No	USA 14. Race - American Indian, Black,			
leath r	nue	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.			
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10urs	ed t	45 December 1 51 11 10 11 11 11 11 11 11 11 11 11 11 11	ecedent's Usual Occupation (Give kind o rring most of working life. DO NOT use re	f work done	16b. Kind of Business/Industry			
36 in 72 han "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		eurea)				
J with giene	Eo	12th 17. Father's Name (First, Middle, Last)	SELF EMPLOYED	on /First Middle	PRIVATE Maiden Surname)			
21215-0036 Meltal Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner, must be potified at once.	BeC	TIMOTHY L. MURRAY		O. BROW				
(A) 2 4 9	P		Mailing Address (Street and Number or					
5 0 2 0 1			21 W. ORD WAY ANAH	EIM, CA.	92802			
imore, M Pages 1 and 2 ment of Health tant: If iten 2 or other traun			Disposition (Name of cemetery, y or other place)	Date	20c. Location - City or Town, State			
Page ment cant		4 Donation 5 Other Specify: LINCOL	N CEMETERY 10-	-28-11	SUITLAND, MARYLAND			
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other ti		21. Signature of Funeral Service Licensee			KINS FUNERAL HOME, INC.			
Physician		23a. Par/I. Enter the disease, or complications that caused the death. Do not e			SVILLE, MARYLAND 20785			
/Medical		failure Listionly one cause on each line.	inter the mode of dying, such as calculac	or respiratory arr	est, shock, or heart Approximate Interval Between Onset and Death			
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876 tificat ng ph	N/LI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn	ancv	23d. Date of delivery Month Day Year			
eath certifications for use as 1	Sici	4 Pregnant at time of death 5	Other (Specify)					
t the de by the ached f	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in	the underlying seven sives in Best I	Dog Did to	bacco use contribute to the cause of death?			
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of Vital Records, ig Physician: The law require the tart from the tar this certificate has been sineral director, page 2 should be	Completed		· · · · · · · · · · · · · · · · · · ·	24a. Was a				
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tal Rec		25. Was case referred to medical	26.Place of Death (Check	1 Yes	2 No 1 Yes 2 No			
Vita ysicia ysicia ysicia	m	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outp.	Other —		Residence 6 Other:			
ing Ph		27. Manner of Death 28a. Date of Injury 28b. Tim	ne of Injury 28c. Injury at Work?	28d. Describe h	low injury occurred			
ttendi Heath. He f	atio	1 Natural 5 Pending Oct 17, 2011 Pearl) 1700 hi	1 Yes 2 No	Motorcyclist	involved in collision			
Division pital or Attendio ours after death. earl Director: ♣ filled in by the fa	Certification	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	, street, factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Rural Route Number, City			
Ospita hours uneral		4 Homicide determined (Specify) Roadway 29a. Certifier Certifying Physician: To the best of my knowledge, death		1000 Block Ke	nilworth Avenue, Washington, DC			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		one) 2 Medical Examiner: On the basis of examination and/or inve	occurred at the time, date and place, and stigation, in my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)			
	2	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)			
Jan.			O.C.M.E.		October 18, 2011			
100		Name and address of person who completed cause of death (Item 23a) Ana Rubio MD.	Baltimore Street Baltimore M	D 21223				
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Land 1					
		OCT O Q 2011 22	BITA PLAN					

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Date of Death ecedent's Name (First, Middle, Last) Physician/ Medical ounty of Death not institution, give street and number) 4b/City, Town, or Location of Death **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign If Under 7. Age (In yes. last birthday) Funeral Sept 20 Country Maryland Hours Min 1 ₹ M 2 □ F Ϋ́1927 84 219-22-6293 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10h County 10c. City, Town or Location at Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified a 1 🗌 Yes 2 😾 No MD Baltimore Arbutus 10g, Citizen of What Country? 10f. Zip Code Completed by Funeral USA 21227 5518 Heatherwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status Black, White, etc 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) R E Michael Warehouse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Charlotte Kohffer George W. Meyers Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 518 Heatherwood Road Arbutus Maryland 21227 Antoinette Meyers-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition ☐ Burial 2 XI Cremation 3 ☐ Removal from State Oct.25,2011|Glen Burnie Maryland Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. . Signature of Ednoral Service Licensee the 1328 Sulphur Spring ROad Arbutus Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastane Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Division of Vital Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 🗆 No ☐ Yes Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it 26. Place of Death (Check only one) Be 25. Was case referred to medica examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) injury 5 Pending Natural 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🖂 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 While D4768 3 שמכר 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltonie

Registrar DHMH 17 Rev 7/2009

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Smith

32. Registrans Signal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 10:20p^M Lenna Mays Mae Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Hospice 8. Date of Birth (Month, Day, Year) Mar 1, 1939 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Min. Days Hours 1 M 2 X F West Virginia Director 212-36-4660 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No MD Jessup Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20794 8323 Darkwood Court within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Sales Sales Representative 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Ruth Crickard Ralph Hamilton other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 sh ment of Health a tant: If item 27 is 7344 Mockingbird Circle Glen Burnie, MD 21060 Dawn Metcalfe/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State Final Journey Crematory 10/27/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784 Clarskyille. MO1251 Beverly L. Heckrotte, P 23a. Part 1. Enter the grease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUPRAGLOTTIC CANCER Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atte Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 X No 1 Yes 2 No after death.

Director; After this certificate filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 E 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie OCTOBER 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MD 21044 DANIEUE DOBERMAN, MO 31. Date filed (Month, Day, Year) 2. Registrar's Signaure State 2 8 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER 26,2011 Physician/ MARY ETTA MARKS 8:22A. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE TOWSON GILCHRIST HOSPICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Social Security Number **Funeral** Days Min MAY 28, 1945 Hours MARYLAND 218-44-6014 1 🗆 M 2 💢 F Director 66 Yrs Usual Residence of Dece 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location at Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🔀 No NOTTINGHAM BALTO. MD. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21236 Funeral 22 ROSEHILL COURT USA 27 is marked other than "natural", or items traumatic event, the Medi-al Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 😾 Married Completed by 1 ☐ Yes 2 💢 No If Yes, Give WHITE 1 Yes 2 X No Specify. Specify 3 Widowed 4 Divorced Year or Dates Give kind of work done during most of working ife. DO NOT use retired! 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 MARY M. JAMES ORIE C. SIMMONS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROSEHILL COURT NOTTINGHAM, MD. 21236 1 and 2 s f Health item 27 **SPOUSE** THEODORE MARKS 20a. Method of Disposition
1 □ Burial 2 🏅 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o once. GLEN BURNIE, MD. 10-27-2011 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY SCHIMUNEK FUNERAL HOME, INC. 22. Name and Address of Facility re of Funeral Service Licensee NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one caus Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ O Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner Due to (or as a consequence of) Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial Physician/Medical certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 U Yes 2 No the á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? 2 🗌 No Yes 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ospice 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending death. 1 Yes 2 No М Accident Investigation filled in by the Suicide Could not be

State

To the Hospital o within 24 hours af To the Funeral Di

Medical

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 06-2011 4 Homicide

29a. Certifier

29b. Sign

(Checl

determined

28

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Straheen 16701 H. Charles

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

T8215000

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

10-28-11

, Suite 4105, Baltimore, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	amend For State Registrar	#9 state of M	arylan		aftment of F tificate of D			giene Reg. No.	201	1 31.1.51
	Physicia	n/	Decedent's Name (First, Middle, L	ast) Jack		Maxw	e11		2. Date of Dea Month Octobe		. 2011	3. Time of Death 1:55 P. M
-	Medic Examin		4a. Facility Name (if not institution, gi	ive street and number)			4b. City, Town, or	Location of Death		\neg	County of Deat	
-			Genesis Elder				Balt	imore If Under 24 Hrs.	8. Date of Birt			Arunde1 hplace (State or Foreign
	Funeral Director		235 18 1150	Sex 1 X M 2 □ F	92	st birthday) Yrs.	Months Days	Hours Min.	(Month, Da 07/09)	1919	Wes	Virginia
	and show	ō	Usual Residence of Decedent 10a. State 10b. County			, Town or Lo						10d. Inside City Limits
	Maryl 28a-f notifie	Director		Arundel		Baltim				10- Citia	ten of What Co	1 Yes 2 X No
	with the 23a or sst be r	Funeral D	10e. Street and Number 613 Hammonds La	ane			10f. Zip Code	1225		0	.S.	
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Vear or Dates.	No		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🛣 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Ame Black, White Specify:	
21215-0036	72 hours "natur edical	nplete	15, Decedent's (Specify only highest	Education		(Give	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	ing	16b. Kin	nd of Business	Industry
212	within giene.		Elementary/Seconday (0-12) 12th	College (1-4 or	5+)		tal Carri	er		Pos	st Offi	ce
Maryland 2	e filed ontal Hyge ed others event,	To Be	17. Father's Name (First, Middle, Las	ay Maxwell				18. Mother's Nam	e (First, Middle, Copun	Maiden S	urname)	
aryli	ould bad Me mark	ľ	19a. Informant's Name/Relationship			19b. Mailii	ng Address (Street	and Number or Run		r, City or T	Town, State, Zi	o Code)
	alth a m 27 is		Michael Maxwel	1			Box 254					vania 16313
nore	age 1 ar ent of He nt: If iten y or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State			esition (Name of matory or other placen Mem. P		Date 4/2011		cation - City or Burni	e, Maryland
Baltimore,	permit. Pa Departme Importan any injury once,		21. Signature of Funeral Service Lice		- 010	/ 22	2. Name and Addre	ss of Facility Go	nce Fun	eral	Servic	
			2 a. Part 1. Enter the diseas, a	mplications that cause	ed the deat	70				_	,	Approximate Interval Between
-	Physician/		2.1a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or t.s. a consequence of):									Onset and Death
-	Medical Examiner			Due to (or es	a onsequ	ience of):						
	eit d	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):						
	be executed sician and burial-transit	dical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):						
09	ate be exe ohysician a the burial	dical		d								
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♠ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant g ☐ Unknown	2 Feta at time of o	al death 3	Ectopic pregnand Other (specify)	cy		2	23d. Date of de Month	elivery Day Year
s, P.O.	iires that the signed by t Id be detach	d by Ph	Part II. Other significant conditions Peripherel		but not res	ulting in the i	anderlying cause gi	ven in Part I.				o the cause of death? Probably 4 Dunknown
Vital Records,	sician: The law require s certificate has been si lirector, page 2 should	Complete							24a. Was auto perf 1 \(\sum \) Yes		prior to	utopsy findings available completion of cause of
tai	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	lace of Death (Chec				
- <u>Z</u>	y Physical this ceral direction	e: 10	1 Yes 2 No 27. Manner of Death	1 L Inpa 28a. Date of in (Month, D	ury	28b. Time o injury	nt 3 DOA 28c. Injur	y at	ome 5 Resi 28d. Describe			city)
ion	tending leath. or; Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	tion			M 1 🗆	Yes 2 □ No	005 1	Dave et end	Alumbar or Pi	ural Route Number,
Division of	al or Attendii s after death. I Director: A d in by the fu		4 ☐ Homicide determin	ed 28e. Place of in building, e	itc. (Specify	me, iarm, su	eet, factory, office		City or To		TNUTTIBET OF TH	arar riodio riorito oi,
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Chack 2 Medical Ev	hysician: To the best of the best of the basis of the basis of three Practioner: To the basis of	examination	n and/or inves	stigation, in my opini	on, death occurred a	at the time, date	and place,	and due to the	cause(s) and manner stated.
	To the within To the comple	Σ	29b. Signature and title of certifier	arse i radioner, le ar	0 0001 01 111	y tutomicage,	29c. Licens	e number			e signed (Mon	
			1	~ M	4.			3465			0/21/1	21061
Ux	1/		30. Name and address of person when the same and address of person address of person and address of person address of pe		death (Item	1 23a) (Type, 1	Print) PKW	ad Par	d 66	en P	Sinic	5 MD
	Sta Registr		31. Date filed (Month, Day, Year)	- A M A M	rer's Signa	A Lo	extel					
	negistr	ar	111.120	WILL CORNE		7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) (0:05A OVIC County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Anno 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac PA 7. Age (In vrs. last birthday) Social Security Number 1 🗆 M 2 🗶 F Hours Min 08/29/1931 80 Yrs. 217 26 6076 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County Anne Arundel Baltimore 1 Yes 2 X No Maryland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code U.S. 21225 110 Camrose Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ years Elementary/Seconday (0-12) Lutheran Church Early Childhood Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olive Koontz Forest Wilbur Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 Timothy Myers / Son 110 Camrose Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 10/24/2011 Baltimore, Maryland Cedar Hill Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas, or shock, or heart failure. List only Onset and Death Immediate Cause (Final disease or condition

Physician/ Medical Examiner Physician/Medical Examiner the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show

Director

Completed by Funeral

Be

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"natural", or items 23a or 28a-f sho

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho

th and Mental Hygiene.
7 is marked other than "natul traumatic event, the Me Ical

other t

permit. Page 1
Department of I
Important: If its
any injury or of

Baltimore, Maryland 21215-0036

attending physician for use as the buria ed by the a signed k d be deta Completed by page 2 s after death.

I Director: After this certifica of in by the funeral director, p

has

Division of Vital Records, P.O. Box 68760

je je	Sequentially list conditions,	b. Due to (or as a consequence)	Due to (or as a consequence of):								
dical Examiner	if any, leading to immediate causs. Enter Unserping Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequence)									
Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Ectopic pregnancy 23d. Date of death of										
ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to										
Somplet	obstructive u	iropathy			24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of es 2 No				
e	25. Was case referred to medical			26. Place of Death (Che	ck only one)						
To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing I	lome 5 Residence	6 Other (Spe	cify)				
Certificate: 1	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju						
I Certif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		ory, office	28f. Location (Street a City or Town, Star	ind Number or Ri te)	ural Route Number,				
Medical	(Check 2 Medical Examin	ician: To the best of my know ner: On the basis of examination e Practioner: To the best of m	n and/or investigation,	in my opinion, death occurred	at the time, date and place	ce, and due to the	cause(s) and manner sta				

29c. License number

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

within 24 hours aff

To the Funeral Di

completed filled in

within 2 To the I

. Registrar's Signat

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per verb., g920, 10/28/201 ldhb
Certificate of Death
Reg. No. 1 - For State Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2/ Month Physician/ 15/3 PM Dolores G. McMillan 7.01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A RALTIMORE HOSPITAL AGNES 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min (Month, Day, Year) Apr 14, 1936 1 M 2 XF MD 75 216-32-9210 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b County 10c. City, Town or Location death with the Maryland Director 1 ☐ Yes 2 ☐ No **Baltimore** MD **Baltimore City** 10g. Citizen of What Country? 10e Street and Number 10f, Zip Code Funeral U.S.A. 21205 811 North Belnord Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: **Black** If Yes, Give Year or Dates Specify: 3 Nidowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hospital **OR Technician** 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Bertice Dunkley George Dunkley 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 North Belnord Avenue Baltimore. MD 21205 Norlene Cottman Important: If item 27 any injury or other tra Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 5 cemetery, crematory or other place) 1 Burial 2 Kremation 3 Removal from State Catonsville, Maryland Oct 25, 2011 Department Metro Crematory, Inc. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 any ir Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ruotured Infrarenal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): attending physician Physician/Medical the Delores 1-1/11/11/11 be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No or Attending Physician: The law requires that the death Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 this certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) Nursing Home \(\frac{\frac{1}{2} \text{Residence}}{2} \) Residence \(6 \) Other (Specify) 2 X No ၣ 1 Yes 1 Minpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 X Natural iniury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and the c 29c. License number 29d. Date signed (Month, Day, Year) GLUFFREDA, MD P25907 21/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVE BALTIMORE, MD Z1229 900 JOHN GULFFRED

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

OCT 28

Mc Millian,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2011 4:45 A Jeffrey October A. MacDonald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** (Month, Day, Year) Hours 273-38-7994 Usual Residence of Decede 1**x** M 2 □ F Director Yrs. Sept 6, 1946 Ohio 65 show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ms 23a or 28a-f sho must be notified at Director 1 Tes 2 No Silver Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 20904 12608 Two Farm Drive or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14 Race - American Indian. Examiner Armed Forces?

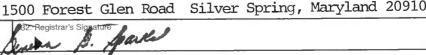
1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+) the Airline Pilot Assoc 5+ <u>Senior Negotiator</u> other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental 2 Lewis Marjorie Kenneth MacDonald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is a any injury or other traumone. 12608 Two Farm Drive Silver Spring, Maryland 20904 Judith Murdock/wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Svc. 10/27/2011 Hanover, Maryland 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 21. Sign three of Funeral Service L uanita 4112 Old Columbia Pike Ellicott City, MD 21043 thomas 23a. Part Tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardio Pulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypovolumic Shock Sequentially list conditions Examine tan, leading to in radiate cause. Enter Underlying Cause (Disease or injury that initiated events Rupture of Abdominal Aortic Anuerysm burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death
Unknown Month 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2X No has funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 X No 1 Yes ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred I or Attending F after death. 1 🔀 Natural 5 Pending work? 2 🗌 No the f Accident Investigation Could not be Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined Medical

the Hospital

Sirak Lemma 31. Date filed (Month, Day, Year) State Registrar

29a. Certifier (Check



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d Date signed (Month, Dav. Year)

29c. License number

D620

To the Funeral Director: within 24 hours after

1 Yes 2 No		
	. Time of Injury 28c, Injury at Work?	28d. Describe how injury occurred
1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No	
	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, Cit or Town, State)
9a. Certiffer 1 Certifying Physician: To the best of my knowledge, denoted by the best of my knowledge, denoted by the basis of examination and/or and manner stated.		at the time, date and place, and due to the cause(s)
9b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Carol Hallan	O.C.M.E.	October 20, 2011

OCME

30. Name and address of person who completed cause of death (Item 23a)

8

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD

gistrar's Signatu

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 19 4:07PM Physician/ 201 Jan Nelson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 1951 1 🕅 M 2 🗆 F Months Days Sept 22, Maryland 216-58-6643 60 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10c. City. Town or Location at 10a State Director Examiner must be notified 1 Yes 2 X No Prince George's Greenbelt MD 10g. Citizen of What Country? 10f. Zip Code 5 10e, Street and Number Funeral items 23a USA 20770 22 Ridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc 5 2 should be filed within 72 mounts alth and Mental Hygiene.
127 is marked other than "natural", or δ 1 Never Married 2 Married Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Completed 3 Widowed 4 X Divorced Ne/Son , Jar Baltimore, Maryland 21215-00 unk nnk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ruth Burma hiett မ Maynard Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Broadkill Road Rte 16 Milton, DE 19968 Department of Health ar Important: If item 27 is any injury or other traunonce. Kellie Shockley/sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛣 Other (Specify) in state 28 Hantend Addat of figilit Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between shock Onset and Death Immediate Cause (Final Ph_sician/ (indus) disease or condition resulting in death) Medical Examiner Emphasema Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury Examine physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🔲 Yes been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2. performed Yes 2 death?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician; 24 hours after death. 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မူ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number purchis posdem , ~ 18992000 10/20/2011. GLENN DALE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS ROAD SUITE AND 200 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 36457 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:20 P.M Lewis B. Newberg October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 410 Hamlet Club Drive Condo #103 Edgewater Anne Arundel 9. Birthplace (State or Foreign Country) New York Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) 04/06/1939 1 X M 2 D F Months Hours 052 32 3303 72 **Director** Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Edgewater 1 Yes 2 X No Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S. 21037 410 Hamlet Club Drive Condo #103 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Viet Nam Year or Dates. Viet Nam 1 ☐ Yes 2 1 No Specify: White Completed 3 Widowed 4 Divorced other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Ear, Nose & Throat Doctor (Specify only highest grade completed) College (1-4 or 5+) 5+ Years Elementary/Seconday (0-12) Page 1 and 2 should be filed within rment of Health and Mental Hygiene. Fant; If item 27 is marked other than jury or other traumatic event, the N Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ma1 Newberg Ivernia Bass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laureen Collins / 410 Hamlet Club Drive #103 Edgewater, MD. 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 s
Department of IImportant: If ite
any injury or ot
once. 1 Burial 2 🔀 Cremation 3 🗋 Removal from State 10/25/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ediate Cause (Final Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, Immediate Cause (Final CORONALY ARTURY DISEASE Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): _ Examiner CANDIO VASCULAN ARTEMOSCI Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) inding physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the at a be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CARDIOMYOPAINY Division of Vital Records, 1 Yes 2 No 3 Probably Completed DIABETES 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\vec{P}\) Residence 6 \(\sum \) Other (Specify) 2 No Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending Investigation Accident 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21776 OCTOBER 24, 2011 by/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SULLY 1, MUNDRA 300(5 H HANDER ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:30 AM Year 2011 Month October 26, Physician/ Judith Mary Patten Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore 600 Light St. Apt. 818 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 1934 New Jersey Days Min **Funeral** (Month Pay 21ar) 009-20-4590 1 M 2 XF Director 10d. Inside City Limits show 10c. City, Town or Location 10b. County death with the Maryland 10a. State Director 1 Yes 2 No notified Baltimore 28a-f MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō ms 23a or must be United States 21230 Funeral 600 Light St. Apt. 818 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. iral", or items? 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinance. 1 Never Married 2 Married by 1 Yes 2 No Specify: White Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Public School System Elementary/Secondary (0-12) College (1-4 or 5+) Educator 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Margaret Brewster Arthur Edwin Patten ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13525 Silent Lake Dr. Clarksville, MD 21029 Nora Kralowetz /Daughter Datact 28, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Beltsville, Maryland 1 Burial 2 KCremation 3 Removal from State 2011 Chesapeake Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee MO1585 22. Nation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death chr Adeno concinona Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine the burial-transit Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy use 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ___ Year Month Day in the past 12 mont signed by the atter Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Probably 4 Unknown þ 1 Yes 2 No Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? page 2 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) 25. Was case referred to medical director Be Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2- No ပ္ 28d. Describe how injury occurred 28b. Time of 28a. Date of injury 28c. Injury at funeral 27. Manner of Death I Director: After the in by the funeral Certificate: (Month, Day, Year) injury 1 > Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 4 Homicide filled in by determined within 24 hours a

To the Funeral C

completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date file

Anvies

32. Registrar's ignatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 25 Day 2011 Physician/ 2:12 A. William Thomas Ptaszynski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Sex 1**XX**M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Dec. 30 Year 1944 220-42-9728 Maryland 66 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Director notified 1 Yes 2 XNo Maryland Harford Street 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 must be n Funeral 21154 United States 931 B Federal Hill Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Medical Examiner Armed Forces? Black, White, etc. 6 þ 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Dealer Pricipal Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Hauptmann Michael Ptaszynski Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau MaryAnne Ptaszynski / Wife 931B Federal Hill Road Street, Maryland 21154 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Oct. 27 Evans Funeral Chapel Bel Air 1 Burial 2 Cremation 3 Removal from State 2011 Forest Hill, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Evans FuneralChapel & Cremation Service—BelAir
3 Newport Drive Forest Hill, Maryland 21050 21. Signatur / f Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ocard Intacction Onset and Death Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical Due to a r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dua to (ur as a sur sequence ut) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month been signed by the atte should be detached for 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Dystipideni 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 🗌 Yes 2 🗍 No this certificate 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ္ခ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director, After injury 1. Natural 5 Pendina 2 Accident Investigation 6 Could not be Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: The the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 2011 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 500 hpper

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 05 f ea Medical County of Death 4a. Facility Name (if not institution give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Isville ock sadmea 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 9.3 Yrs. If Under 24 Hrs. 8. Date of Birth 6. Sex 1 M 2 □ F If Under 1 Year **Funeral** kesville Director Usual Residence of Decedent or items 23a or 28a-f show 10d. Inside City Limits Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Be Completed by Funeral Director 1 Yes 2 No paltimore 10g. Citizen of What Country? 10e. Street and Number 21030 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2

If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Şeconday (0-12) College #1-4 or 5+) Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surriame) မ Pa /Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 19a. Informant's Name earre Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -orest 4 ☐ Donation 5 ☐ Other (Specify) Rd, Monkton, ND 2111,1 permit. 22. Name and address of Facility 16924 Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Pinal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 🗌 Yes 2 No Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 1 Yes 2 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ð 28c. Injury at 28d. Describe how injury occurred Certificate: 1 V Natural 5 \square Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check unity of Cartifying Nurse Practioner To the Lest of my knowledge. Joseph Sonia at the time, date and plants, and due to the obuse(s) 29b. Signaturd and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3801

State Registrar

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Dea

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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pleted filler			2 Medical E	xaminer: C	n the basis of	examinatio	n and/or invest	igation, in my opir	e, date and place, nion, death occurred the time, date and p	at the time, date	and place,	and due to the o	cause(s) and manner st	ated.
8 8	2	9b. Signature and		Piles	v. V.	, Mr)	29c. Licen				e signed (Month		
	3	0. Name and add	ress of person v	who comple		death (Item	23a) (Type, P		ane	Colum		MD	21044	
	3	1. Date filed (Mon	OCT 2	0.004	32. Regis	trar's Signa	ture			• • • • •				_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ October William Gary Pike 2011 22:21 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) eb. 12 1 XM 2 □ F Hours Kentucky **Director** 400-70-7124 60 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 Meeks Drive 21001 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Evamin ģ 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Roy Pike Margaret (unk) Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cyndie Pike / Spouse 111 Meeks Drive, Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp: 10-26-2011 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 2 No 1 🗌 Yes Yes • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certific. **Division of Vital** filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending __.ural ☐ Accident ☐ Sui-1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ON 6:15 AM M Medical Name (if not institution, give street and number 4b. City, Town, or Location of Death Baltines **Examiner** 4c. County of Death Care Timore Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) unk If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours 1 □ M 2 😿 F Apr 8 , 1951 Director 60 <u> 220-76-9913</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Funeral Director 10d. Inside City Limits MD 1 √ Yes 2 □ No Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 819 N. Fremont Avenue 21217 USA unk 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 6 ģ Black, White, etc. 1 Never Married 2 Married unk 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) lith and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Future Care Sandtown 1000 N. Gildmore Street Baltimore, MD 21217 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any Injury or ot once. 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State $4 \square$ Donation $5 \cancel{X}$ Other (Specify) in state neral Service Licensee State and Address of Facility and 655 W. Baltimore Street Director Baltimore, MD 21201 Part 1. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on ach line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be for use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death g Unknown P.O. þ s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s Hospital or Attending Physician: The this certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? မ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident 2 No within 24 hours after deatl

To the Funeral Director:
completed filled in by the Investigation Suicide Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 24, 2011 8:35 P M Phoebus Michael W. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Harford** 4b. City, Town, or Location of Death Examiner Havre deGrace 211 Spectacula Bid Drive Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 62 Director 218-52-2790 1**X** M 2 □ F Maryland June 24,1949 Usual Residence of Deced show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director items 23a or 28a-f s ner must be notified 1 Yes 2 X No Havre DeGrace Harford Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 211 Spectacular Bid Drive 21078 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status an "natural", or ite Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Graduation Regalia 4 Business Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marguerite Hartge William S. Phoebus 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Spectacular Bid Drive Havre De Grace, Md. 210/8 Barbara Phoebus Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 10-26-2011 Glen Burnie, Md. Atlantic Crematory 4 Donation 5 Other (Specify) Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 610 W. MacPhail Road BelAir, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic ancreatic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Disk to for sea a none late removi If any, leading to immediate cause. Enter Underlying burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ses 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 certificate 1 Yes 2 No or Attending Physician; the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 Residence 6 \(\text{Other (Specify)} \) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 Yes 2 No Accident Investigation within 24 hours after deal To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined the Hospital Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

29b. Signature and title of certifie

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Me Tang 6569 N. Charles

29c. License number D 0 0 6 9 3 2 9

St. Suite 201.

29d. Date signed (Month, Day, Year) 10/25/2011

Baltimore, MD 20204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year Physician/ Month Bertrude Pressley 10: 40P M 1) citaber Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Dunda1k 1621 Gray Place Baltimore Co. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) Hours 220-22-9390 **Director** 1 □ M 2 🗓 F Yrs 95 June 4, 1916 Kentucky Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XXVI MD Baltimore Dunda1k ms 23a or must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t Funeral 1621 Gray Place 21222 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 9 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify Specify. "natural" Completed 3 X Widowed 4 □ Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental his marked o arrit. Page 1 and 2 should be file erartment of Health and Mental I or ortant: If item 27 is marked on in injury or other traumatic eve ပ Norman Dearfield Mary Lunsford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karol Potter (Daughter) 11 Patapsco Ave. Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Oak Lawn Cemetery 10/28/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Der arti Import any inj once. ²²Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland_ Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ un KNOWN ORIAIN Neoplasm of disease or condition resulting in death) [™] Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ا 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital o the Hospital or Attending Physic within 24 hours after death.

o the Funeral Director: After this ce completely filled in by the funeral directors. Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 h (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) ns RajapaneM.D 00057465 10/26/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MDZ1209 5203 2835 Smith AV · S. Rajapakse IM.D 32. Registrar's Signature 31. Date filed (Month, D State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Robert S. Schmelz, III 2011 10:10 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Carroll Westminster 5. Social Security Number 6. Sex If Under 1 Year If Under **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 1 X M 2 D F (Month, Day, Year) 947 Mary land **Director** 217-50-1690 64 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No MD. Baltimore Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18237 Falls Rd. 21074 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black White etc. þ 1 Never Married 2 Married 1X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. 3 Widowed 4 Divorced Completed Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Police Police Officer Be 1 and 2 should be of Health and Mental Heitem 27 is marked or 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethel Mae Seitz Robert S. Schmelz, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Schmelz/ Brother 6518 Sherwood Rd. Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Co. 11-2-11 Towson, MD. 21. Signature Funeral Pervice Lice see 22. Name and Address of Facility on Funeral Home, Inc. 1050 York Rd. Towson, MD. 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cononov Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has a completed filled in by the funeral director, page 2.3 autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ 1 Tyes 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate; 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗀 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and ress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 25 John Joseph Simmons 201T 5:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 127 Ridgefield Road Lutherville Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Min. Hours 213-26-2687 Director 1 X M 2 🗆 F 80 Jan. 16, 1931 Maryland 28a-f shov 10a. State 10h. County 10c. City, Town or Location notified at 10d. Inside City Limits **Funeral Director** MD. **Baltimore** Lutherville 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code the Medical Examiner must be 10g. Citizen of What Country? 23a 127 Ridgefield Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify Completed 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Health and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Banker Banking other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ be Michael F. Simmons, Sr. Catherine H. Flury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra Matthew Simmons/ Son 6407 Pinehurst Rd. Baltimore, MD. 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus 10-28-11 Dundalk, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Frieral Service Licenses 22. Name articless Powson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1/Enter the disease or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ျပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No eral Director: A filled in by the fi Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29c. License number person who completed cause of death (Item 23a) (Type, Print) UNES 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Registrar	State of Maryland / Dep Cea	artment of Health a rtificate of Death		giene 201	34468			
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Carol Jo Strang			2. Date of Dea Oct. 2		3. Time of Death 1:22 p _M			
ر مهيدي	Examin	er	4a. Facility Name (if not institution, give stre Suburban Hospital	et and number)	4b. City, Town, or Location of Bethesda	f Death	4c. County of Dea				
	Funeral Director		5. Social Security Number 220-56-4324 6. Sex Usual Residence of Decedent	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year I If Under 2 Months Days Hours	8. Date of Birth (Month, Day 12/20/	(, Year) Co	rthplace (State or Foreign ountry) NJ			
	laryland 3a-f shov iified at	Director	10a. State 10b. County Montgomer	y 10c. City, Town or Lo Silver Sp				10d. Inside City Limits 1 ☐ Yes 2 ☒ No			
	with the M 23a or 28 ust be not	Funeral Dir	10e. Street and Number 3770 Bel Pre Road		10f. Zip Code 20906		10g. Citizen of What C	0g. Citizen of What Country?			
9036	ırs after death ural", or items I Examiner m	by	11. Marital Status 1 12. Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Vac 2 X Ma	Was Decedent of Hispanic Orig if Yes, specify Cuban, Mexican, 1 Yes 2 KNo Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Whi Specify: W				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) (Give College (1-4 or 5+)	dent's Usual Occupation kind of work done during most O NOT use retired) Lstant Manager		16b. Kind of Business/Industry Banking				
land 2		To Be	17. Father's Name (First, Middle, Last) James Irving Stran	g		Maiden Surname) rritt	*				
, Mary			19a. Informant's Name/Relationship (Type, Barbara Strang, sis		ng Address (Street and Number) Woodview Term	or Rural Route Number r. Laurel,	. City or Town, State, Z MD 20707	(ip Code)			
imore			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 XXOnation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Science Care 20c. Location - City or To cemetery, crematory or other place)								
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service incension		2. Name and Address of Facility 33 Gist Ave. S						
a ta	Physician/		23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one commediate Cause (Final disease or condition	ions that caused the death. Do not entrause on each line. Cardiac		ardiac or respiratory arr	est,	Approximate Interval Between Onset and Death			
	Medical Examiner	L.	resulting in death) Sequentially list conditions, b	Due to (or as a consequence of): Decompressive Ce	rvical Laminec	tomy 24°					
	cuted nd ransit	edical Examiner	ril any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	DBS to for as a consequence of,							
092	cate be executed physician and s the burial-transit	dical E	resulting in death) Last	Due to (or as a consequence of):							
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Σ	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of do	elivery Day Year			
ds, P.O.	quires that the en signed by ould be detac	by	Part II. Other significant conditions contrib	outing to death but not resulting in the u	inderlying cause given in Part I.		bacco use contribute t	to the cause of death? Probably 4X Unknown			
Division of Vital Records,	: The law rec cate has ber r, page 2 sho	Completed				24a. Was a autop perfor 1 🗆 Yes	sy prior to rmed? death?	utopsy findings available completion of cause of			
Vital	hysician nis certif il directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 \sum No	oital: 1 Inpatient 2 ER/Outpatier	26. Place of Death	n (Check only one) sing Home 5 🗌 Resid	ence 6 Other (Spe	ecify)			
on of	ending P eath. or: After t the funers	Certificate:	27. Manner of Death	28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c, Injury at work? M1 \bullet Yes 2 \bullet I		ow injury occurred				
Divis	ital or Att ins after d ral Direct		4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Tow					
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, after this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical Examiner: only one) 3 Certifying Nurse Pr	n: To the best of my knowledge, death of On the basis of examination and/or inves actitioner: To the best of my knowledge	tigation, in my opinion, death occ	curred at the time, date a	nd place, and due to the	e cause(s) and manner stated.			
-4-	With		29b. Signature and title of certifier	m.	29c. License number 2942	2	29d. Date signed (Mon	th, Day, Year)			
_			Jeff Jacobsov	leted cause of death (Item 23a) (Type, F	and I former an arrange of the	own Rd.	Betheso	la, MD			
	Stat Registra		31. Date filed (Month, Day;-Year) -	32. Registrar's Signature	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34469 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elsie M. Shoul 4:45 P M 2011 October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2703 Chesley Avenue Parkville Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year)
April 10, 1920 1 □ M 2 🔀 F Days Hours 91 Maryland 218-03-0800 Director Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with Funeral 2703 Chesley Avenue 21234 United States 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) Hygiene. College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other th:
any injury or other traumatic event, the longe. 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Hoffman Marie Ende 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Bagwell (Son) 1720 Wadsworth Way Baltimore, Maryland 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley Mamorial
Cardens 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 28, Timonium, Maryland 2011 21. Signature of Flureral Service License 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) aidid Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Director: After this certificate 1 L Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 Ty-No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XXNatural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Investigation
6
Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral C cal Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examine? On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signal completed cause of death (Item 23a) (Type, Print) 2128 KeyMD tall nous ar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stiegler 2011 Ε. October 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 6504 Redgate Circle Catonsville Social Security Number 8. Date of Birth
(Month, Day, Year)
June 21, 1916 If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Hours Maryland **Director** Yrs. 216-09-4123 95 June Usual Residence of Deceden 28a-f show 10a. State with the Maryland must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No <u>Pasadena</u> Marvland Anne Arundel ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8196 Forest Glen Drive 21122U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: "natural", Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than 9 Ed Vern Plumbing Co. N/A P1umber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ William Η. Bertha traumatic Stiegler Frisch Page 1 and 2 should ment of Health and Mc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce. Betty L. Ireland (Daughter) 6504 Redgate Circle Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 10/31/2011 Meadowridge Mem. Pk. Elkridge, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and Due to (or as a consequ resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Day Pregnant at time of death Yes 2 No page 2 should be detached signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 🗌 No Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Daughter's Hospital 1 Tyes Other: 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa Other (Specify Residence 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) of Death 28b. Time of 28c. Injury at 28d. Describe how injury o within 24 hours after death.

To the Funeral Director: After Natural 5 Pending injury work? 1 ☐ Yes 2 No filled in by the Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only on certifying Nurge Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu and title f certifier 29d. Date sign 0 30. Name and address of pe 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene									
_			1 - State Registrar	Ce	ertificate of De	eath	F	Reg. No. 2011 3441			
Н	Physicia	an/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea				
	Medi Examir		4a. Facility Name (if not institution, give street and r	(umber)	4b. City, Town, or Lo	ocation of Death	100000	4c. County of,	Death		
أبسب	LAGITII		Gulchrist Hospice		TOLUS	7N/		Balk	CAOR C		
	Funeral	Г	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth		. Birthplace (State or Foreign Country)		
	Director		Usual Residence of Decedent	79 Yrs.			11/29	11931	n		
	land show	tor	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits		
	Mary 28a-1 notifie	Director	MD HARFORD	Joppa					1 ✓ Yes 2 ☐ No		
	ith the	ral	10e. Street and Number	//	10f. Zip Code	_		10g. Citizen of Wha	at Country?		
	ems sems	Funeral	11. Marital Status 12. Was D	ecedent Ever in U.S. 13.	31085 Was Decedent of Hisp	anic Origin? (Spe	ecify Yes or No-	USA 14 Bace	American Indian,		
98	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	Armed	Forces?	If Yes, specify Cuban, I	Mexican, Puerto	Rican, etc.)	Black,	White, etc.		
21215-0036	ours a ntural' cal Ex	Completed by	3 Uvidowed 4 U Divorced Year or	Dates. KOREA				Specify:	lkite		
15	i 72 h	m D	15. Decedent's Education (Specify only highest grade complet	ed) (Give	edent's Usual Occupation The kind of work done during NOT use retired)		ing	16b. Kind of Busin	ness/Industry		
	ed within Hygiene. other tha		Elementary/Secondary (0-12) College	(1-4 01 0+)	decountar	ıt		ACCOUN	ting		
Maryland	e filed ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	/	1	8. Mother's Name	e (First, Middle, M	Vaiden Sumame)	7		
Ž	ould be fill d Mental marked o matic eve		19a. Informant's Name/Relationship (Type, Print)	<i>sa</i>		Mary	LIDKA				
	1 and 2 should be if Health and Men item 27 is marke other traumatic		Charlotte Sheeps -1	(fe 4/1	ing Address (Street and	Number of Hure	Route Number,	a A \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	(DS)		
ore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from	20b. Place of Dispo		, cae	Date	20c. Location - Cit	ty or Town, State		
altimore,	Page ment o tant: If jury or		4 Donation 5 Other (Specify)	DAYVIEW	Cremator	V 10/2	5/11	Baltine	ere no		
Bal	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral Service Licensee	2	2. Name and Address	Facility 5	adjey -		Funeral		
			23a. Part 1. Enter the disease, or complications the	at caused the death. Do not ent	ter the mode of dving. s	Such as cardiac o	or respiratory arr		Approximate		
	nysician/		shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	awair			·	Interval Between Anset and Death		
	Medical Examiner		disease or condition resulting in death) a. Due	to (or as a conseq nonce of):	To the test				13 months		
E		P	Sequentially list conditions, b.								
4.	nsit	Examiner	if any, leading to immediate Cause (Disease or injury	o (or as a consequence of):							
ND	execur an and rial-tra	Exa	that initiated events c c Due	o (or as a consequence of):							
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DHMH 17 Rev 06-2011

ristopher Piel		1- For State Registrar		te of Maryla		rtificate of					Reg. No	20		341
Physici edical Exami		1. Decedent's Name (Christophe			ırm, Jı	r				2. Date of D Month October	Day	Yea	r	Time of Death1946 hrs
)		4a. Facility Name (if n	ot institution,	give street and nu			b. City, Tow	n, or Lo	cation of De			c. County o	of Death	
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Funeral Director		5. Social Security Nur 214–78–418		Sex ZM 2 F	7. Age (In yrs.	1451 birthday)	If Under 1 Months	Days	Hours N	NOV			Foreign	
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Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Higgi ene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	To B	19a. Informant's Name						Street a	nd Number o	or Rural Route I			n, State,	Zip Code)
MD nd 2 sho alth and 27 is		Carolyn St		other 	Lank	Place of Dispos				Easton,			City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite		1 Burial 2 X		3 Removal fro	om State	crematory or oth	er place)				- 1		-	
Itim it. Pag urtment ortant:		Final Journey Crematory 10/28/11 Woodbine, MD 21. Signature of Funeral Service Licenses Appel of the MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MI												
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Division of N To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical	(on our only		ner:On the basis of and manner st	f examination	-								
HSHS	M	29b. Signature and titl	e of certifier	and mainter of				icense n						nth, Day, Year)
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		30. Name and address Donna M. Vin		no completed caus Assistant V			W. Baltin	nore S	treet. Bal	timore, MD	21223			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 17, 2019 7:40 AM M Georges I. Selzer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Towson Edenwald If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 216-28-8856 (Month, Day, Year) **Director** 1 X M 2 □ F 99 Dec 29, 1911 Switzerland Usual Residence of Decedent ms 23a or 28a-f show must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Southerly Road 21286 USA or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forc Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Specify: white "natural", 3

Widowed 4 □ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 0 jeweler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Jacob Shalon Selzer Myriam Brana Schaba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Ammon/executor 3907 Log Trail Way Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 👿 Donation 5 Other (Specify) Funeral S Ron 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease, or conshock, or heart failure. List only mplications that cau Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence or): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Director: After this certificate I d in by the funeral director, pag 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify, Deat Certificate: 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ature and title o 29c. Lice 30. Name and address ause of death (Item 21) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Kenneth Alfred 9:05PM Shaffer October 21, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightwood Center Baltimore Baltimore if Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**☑** M 2□ F Director 235-34-6902 West Virginia 86 10/06/1925 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Director Essex 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code ed other than "natural", or Items 23a or event, the Medical Examiner must be r 1010 George Avenue 21221 U.S.A. Funeral 14. Race - American Indian, 11. Maritai Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1943 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo 1946 þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Steel Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ira Francis Shaffer Mona Bina Cross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Bucklew (Daughter) 5857 N. Church Street, Glen Rock, Pennsylvania 17327 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Md. Veterans' Cemetery 10/28/2011 Garrison Forest, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner / 1 Yes No 27. Manner of Death Other: 1 Inpatient 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Iniury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

12-11

State Registrar

DHMH 17 Rev 1/2001

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 28 201

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOANN FRANCES SCHLIMM OCTOBER 2011 10:27 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL ROSEDALE BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Days Min. MAY 20, 1937 Hours WEST VIRGINIA Director 74 232-56-7493 Yrs Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE FULLERTON 1 ☐ Yes 2 🔯 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 219 LYNDALE AVE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 WHITE 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) al Hygiene. Elementary/Seconday (0-12) HOMEMAKER OWN HOME other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o မ FRANK CAMIGLIANO ANNA SCOLISH 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, S 9 LYNDALE AVE BALTIMORE, MD 21236 permit. Page 1 and 2 st Department of Health al Important; If item 27 is any injury or other trans 219 LYNDALE AVE JOHN SCHLIMM, SR.-HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 10/28/11 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC Sugamo 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 4 NCOPY disease or condition Medical resulting in death) **Examiner** MINVITES Sequentially list conditions, Examiner cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for Month Year Pregnant at time of death Day be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4AGEAC Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No ours after death. eral Director, After this certificate t filled in by the funeral director, page 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 TOOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours a To the Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nulse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 3 7 5 9 Signaturera 29d. Date signed (Month. Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) BAB ATURK ASAN MD 6660

State Registrar 31. Date filed (Month. Day

Registrar

DHMH 17 Rev 7/2009

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MININSOHN

31. Date filed (Month, Day, Year)

M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 04:20 AM Kichard T. Stone October 2011 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours March 9,1952 Director 212-60-9439 59 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at MD Director Baltimore Dunda1k 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip-Code 10g. Citizen of What Country? Funeral 2801 Plainfield Road 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 20 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify ≥ 3 Widowed W Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry & K Distributers Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years 12 Years Sales <u>Saleperson</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Betty Louise Clotfelter Thomas Lawrence Stone မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Country Club Lane Phoenix, MD Mrs. Nancy J. Bromwell(Sister) : If item 2' Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any Injury or once. Hilltop Service Corp. 10/28/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. MODE PC 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CERTIFICATION NO SERVED BY MEDICAL EXAMINER Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASUSTO E

Due n (or as a consequence of): disease or condition resulting in death) 30 mm /Medical Examiner spiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) ul or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Traumatic Brain Injury and subdural hematoma burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physiciar Physician/Medical the as use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery for 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 2 □ No signed by the at ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 2 No 3 Probably 4 Munknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 3 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1⊁ Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA မ filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 Natural 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) MVC unrefrained driver
281. Location (Street and Number or Rural Route Number, 1 ☐ Yes 2 KNo 3 Suicide 6 Could not be determined 4 Homicide City or Town, State) 1 testate cal 95 65-1. Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

hours Hospital 24 hours

completely within 2

State

Registrar

Joan Ko 31. Date filed (Month, Day, Year)

29b. Signature and title of certific

32. Registrar's Signature

and manner stated

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carkel

29c. License number

EES-000

29d. Date signed (Month, Day, Year) October 24, 2011

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Ainac 12broth. toris 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Habor Hossi Baltimore N/A 5. Social Security Number 168 22 0215 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1□ M 2**K**F Months Days Hours 84 Director 05/09/1927 PA. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises. 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Linthicum Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 635 Gayle Drive 21090 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 [2] If Yes, Give Year or Dates 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Sears Dept. Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Robinsky Julia Kuba ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Green / Daughter 5917 Manor House Lane Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 10/24/2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death he cause on each line Immediate Cause (Final **Physician** sotens on disease or condition resulting in death) /Medical r as a consequence of) Examiner Sequentially list conditions, any healing to mine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine in to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? s certificate has the irector, page 2 sl 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Medical Certification: To 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending nours after death.

neral Director: Af 1 □Yes 2 □No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my onlyion, death occurred at the time, date and place, and due to the course of the course o completely (Check only mainer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D54725 October 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mospital 5000 S 3001 S. Honover St. MD 91992 31. Date filed (Month, Day, Year) State OCT 28 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend items 10a-c,e,f per inf g921 11-7-11 vt
State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Rev ROSE 209 :00 A M SALIT Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death COURTLAND GARDENS BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Director Country) 092-14-5831 Yrs. 07/24/1923 88 NY Usual Residence of Decedent 10b. County Orange 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Orlando N/A MD 1 X Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3215 TANEY ROAD 4941 Goucher Ln 32821 USA items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced WHITE of Health and Mental Hyglene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) BOOKKEEPER ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ABRAHAM GROUPP FREIDA PICKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA MISCHEL/DAUGHTER 3215 TANEY ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TEMPLE ISRAEL CEM. 10/30/2011 ORLANDO, FL of Funefal Service Sign 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complication shock, or heart fallure. List only one care that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rmen Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Box (23b. Was decedent pregnant 23d. Date of delivery in the past 10 months? 3 Ectopic pregnancy Pregnant at time of death
Unknown 5 Other (specify) Month Day Year been signed by the a should be detached Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. σ. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Hospital or Attending Physician: The perform 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 [Other မ After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 \(\sum \) Yes 2 \(\sum \) No Accident Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted (Check within 2 To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 1105 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ october 23, 2011 10:55 PM JUDITH SCHWARTZ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death HAMPSTEAD CARROLL GOLDEN CREST ASSISTED LIVING If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Min. (Month, Day, Year) Days Hours **Director** 147-18-3848 1 □ M 2 🗶 F 86 06/20/1925 **GERMANY** Usual Residence of Deced 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 1 Yes 2X No HAMPSTEAD MD CARROLL ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral 1811 ALBERT RAIL ROAD 21074 USA items 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify. "natural", 3 XWidowed 4 ☐ Divorced WHITE Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SOCIAL SECURITY FILE CLERK of Health and Mental Hygien item 27 is marked other the other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ **JOFFE** SCHMIDT ABEL FRIEDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAUREEN MEEKINS/DAUGHTER 3851 DAKOTA ROAD, HAMPSTEAD, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW ORTHODOX 10/27/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical **Examiner** nsur Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician; The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No signed by the atter Year Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been significate has been significated and director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 2 🗌 No 1 🗌 Yes ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence al or Attending Physical after death.

I Director: After this din by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury Certificate: 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide determined City or Town, State) Hospital 24 hours a 24 hours a Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one) 29b. Signat 29d. Date signed (Month, Day, Year) 201

W.

31. Date filed (Month, Bay, Year)

nd address of person

Day, Year) 32. Pegistrar's Sign



completed cause of death (Item 23a) (Type, Print

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Year 11 Day | & Physician/ Dolores Stavely Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Ly of Maryland Medical Center Ballimure, MT. 11.4. 9. Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** Months 1 ☐ M 2 🕱 F 69 05-02-1942 **Director** 213-40-0446 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 🗆 Yes 2 🏝 No Glen Burnie Anne Arundel MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? b Funeral United States 23a 21061 711 James Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o မ Helen Ullman Marion Joseph Stolarski and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Campbell Meadow Rd., Owings Mills, MD 21117 of Health Mark Stavely - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Prk. 10-22-2011 Elkridge, Maryland 4 Donation 5 Other (Specify) of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Du to (or as a consequence of): Examiner respiratory compromis Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No 2 N Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 1 No Other: မြ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 2 🗆 No 2 🗆 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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E.R. PERONTKA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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PGY-1

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nmmc-

NPI 1912292400

PEA ANHITU 435 KI 61 685

22 S. GKGENEST. BALTO. MP. 21220

29d. Date signed (Month, Day, Year)

10/18/11

Please Type of Print in Black, Indelible, Ink Figure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) William Gregory Shipley 2. Date of Death Physician/ Month Year 1LLIAM GREG 530 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENERAL HOWARD COUNTY MOSPITAL HOWARD COLUMBIA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 X M 2 🗆 F Hours 07-13-1946 216-46-8390 65 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 1 🗌 Yes 2 🏝 No 28a-f MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral items 23a United States 8349 H. Montgomery Run Road 21043 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes, Give Specify. Completed 3 Widowed 4 Divorced White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Building Materials Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ William L. Shipley Harmony Zoldak or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 7113 Saddle Road, New Market, Maryland Kim Lund - daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot Meadowridge Mem. Park 10-28-2011 Elkridge, Maryland 4 Dopation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Ligen MMP, Enc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC SHOCK disease or condition 2 years Medical resulting in death) Due to (or as a consequence of) Examiner YEAR CLOSTRIDIUM DIFFICILE Sequentially list conditions, if any, leading to in insolate cause. Enter Underlying Cause (Disease or iinjury 12 years Examiner Dire to (or se a consequence of) YEARS use as the burial-transit LEUKEM)A CHRONIC YMPHOCYTIC and that initiated events Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) oday. B. Navainty INTENSIVIST 26 2011 D0051119 OCT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA MD 21044 CEDAR LAME UDAY BNANAVATY, INTENSIUIST. 5755 32. State arkel Registrar

V DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 0431 Thomas Jacqueline Kaye Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceors Prince Chaver! If Under 1 Year If Under Social Security Number Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min 1 □ M 2 🖵 F JüÏÿ 63 Director 213-54-6651 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director notified Riverdale 1 ☐ Yes 2X No MD Prince George's 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ö must be 23a 20737 United States 5806 Longfellow St. items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 XNo 5 þ 1 X Never Married 2 Married within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Ith and Mental Hygiene.

27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Executive Secretary Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Dailey Thomas Doris Marjean Glenn Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important, If item 27 is any injury or other tratonce. 5806 Longfellow St., Riverdale, MD Vincent W. Thomas / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ★Cremation 3 ☐ Removal from State Chesapeake Crematory 10/26/2011 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AtheroSc 190TIC rdiovasc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a nonsequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami -transit Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a d be detached f g □ Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has certificate 25. Was case referred to medical examiner? Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural work?

1 Yes within 24 hours after death. To the Funeral Director: A 2 🗌 No Investigation 2 Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29h Signature and title of certifier

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vg

3 001

32. Registrar's Signatur

DHMH 17 Rev 7/2009

29c. License numbe

29d. Date signed (Month, Dav. Year)

2011

11-07960

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ledical Exami		DARAYE	AISHIA	T	SON					Month October 23	3, 2011	Year		0107 hrs
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Funeral		Social Security Number 6.	Sex 7. Ac	ge (In yrs. la	ast birthday)	If Under Months		If Under:	24Hrs. Min.	8. Date of Birt	h(MM/DD/Y	1	-:	
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any		Usual Residence of Decedent 10a, State 10b, County		10c. City.	Town or Locati	on							1	0d. Inside City Limits
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th the Maryland 23a or 28a-f sho notified at once.		13923 CASTLE B	LVD # 43			209	904				USA			
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or deat	됩	1 Never Married 2 Marr 3 Widowed 4 Divorce		X No		Yes 2					Speci		LA	CK
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5-0036 ed within 72 tygiene. other than	Completed	***	2		ADMINIS	STRAT						IVAT	E	
21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sh e event, the Medical Examiner must be notiffed at once	Be Co	17. Father's Name (First, Middle, La DARON TYSON	ast)				18		Name (I	First, Middle, M ${ m YL} { m JC}$	HNSON	me)		
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≥ 5 4 2 3		SHERYL YOUNG/MOTHER 3.05 RETURN STREET ALIQUIPPA PA 1.50 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - C											own, State	
		1 Burial 2 X Cremation	3 Removal from S	tate (rematory or oth	er place)			0-2	9-11	PITTS	RURG	. Р	Δ
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To with To con	Me	29b. Signature and title of certifier	and planner stated			29c.	icense	number			29d. Date s	igned (Mont	h, Day, Year)
		4 //					O.C.M	.E.			October	23, 20)11	
DEANE		30. Name and address of person wi				\A/_D=\frac{1}{2}		Ctra-4 F	عدالانت	oro MD 24	222			
			Deputy Chief Med			vv. Balti	more :	otreet, E	saitim	ore, MD 21	223			
St Regist	ate	31. Date filed (Month, Day, Year)	A. Registra	A Signatu	arker									

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F	Funeral Director	Г		Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8, Da	ate of Birth nonth, Day, Yei	9.	Birthplace (State or Foreign Country) Maryland
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	the Man or 28a- e notifie	Director	Maryland N/A 10e. Street and Number		Baltim	ore			10a	. Citizen of What	1 Yes 2 No
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2036	urs after des ural", or ite il Examiner	ρ	11. Marital Status 1	s? No	- 1	Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 🙀 No		nr? (Specity Ye Puerto Rican,	es or No- etc.)		American Indian, White, etc. White
21215-0036	ould be filed within 72 hours after death with the Maryland do Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 10th College (1-4)	or 5+)	(Give I life. Do	lent's Usual Occupa kind of work done di D NOT use retired) lent	vork done during most of working use retired)				
Maryland	should be filed vand Mental Hyg 7 is marked other raumatic event,	To Be	17. Father's Name (First, Middle, Last) Charles Dav	18. Mother							
	2 shilth ar 27 is rtrau		19a. Informant's Name/Relationship (Type, Print) Melissa Sitterly / Mothe	er		g Address (Street a Fairhave			-		, Zip Code) [aryland 21226
Baltimore,	. 0		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate c	emetery, crem	sition (Name of atory or other place rematory) 10	Date 0/25/20	A 1 1	. Location - City	or Town, State
Balti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	1					1		ce, P.A. Maryland 21225
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O Clariford	ith. After this funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ijury :	28b. Time of injury	28c. Injury a work?	_	28d. De	escribe how in		oeciny)
JIVISION	nours after death	Certificate:	3 Suicide 6 Could not be 28e. Place of I	njury - At hor etc. <i>(Specify)</i>	me, farm, stree	et, factory, office		28f. Loc	cation (Street by or Town, Sta		Rural Route Number,
Hospit	Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the basis of the ba	examination	and/or investig	gation, in my opinion	, death occu	irred at the time	e, date and pla	ace, and due to the	he cause(s) and manner stated.
To To	To th		19b. Signature/and Vale of certifier	uch m		29c. License r	umber		29d. l	Date signed (Mo	inth. Dav. Year)
\			10. Name and address of person who completed cause of	death (Item:	23a) (Type, Pri	nt) Spales	lleno	11/5h	cet Bu	1timora	20 2011 Maryland 21225
Ė	State Registra		1. Date filed (Month, Day, Year) _ 33 Penis	trar's Signatu	Bar	_	12760	- /- (, , , , , , , , , , , , , , , , , , ,	<u> </u>	

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Anne Hrun Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland (Month, Day, Year) 218 12 3707 87 Director Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Harwood Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S. 4748-L Flanders Lane 20776 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married "natural", or If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify. White Thompson, Creorge 3 X Widowed 4 Divorced Completed Baltimore, Maryland 21215-00 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12th injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Catherine Jacobs George F. Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Tinsman / Granddaughter 4203 Grace Court Curtis Bay, Maryland 21226 Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 10/24/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses any Baltimore, Maryland 21225 4001 Ritchie Highway mblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Part 1. Enter the disease, shock, or heart failure. Lis Interval Retween Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or a sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 No 3 Probably 4 Unknown Completed been sign 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, l a examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA hours after death.

Ineral Director: After this of filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of leted cause of death (Item 23a) (Type, Print) 30. Name and address of - Svite 305 Glen Burnie MD 2100 31. Date filed (Month, Day, State 8

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 10 01 Medical 4c. County of Death N/A Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner 1ti MOBE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 6 Month, Day, Year 34 Country) 219-26-4775 MD Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location
Baltimore Town or Location 10d. Inside City Limits Director MD N/A 1 X Yes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21213 USA 1831 N. Chester St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Unkwn 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ş Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teachers Aid Various Employers is marked other injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ဂ Carrie Edwards George Uzzle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ada Bell- Daughter 1831 N. Chester Street Baltimore, MD f Health item 27 Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott Trinity Cemt. 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/1/2011 Baltimore, MD Donation 5 Other (Specify) 1101 E. North March Signatur Name and Address of Facility March of Funeral Service Lice 21202 Ave. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e Cause (Final Physician/ MENTIA or condition Medical ng in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 2 🗆 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital: 1 Yes ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending death. Accident Investigation after death completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hariumado Pad #204 Prahville 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34488 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death october 22, 2011 Physician/ 11:10 PM VAUGHN III HAYWOOD Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S CAPITOL HEIGHTS 4207 RAIL STREET g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 54 Hours Min. MAY 14 1957 1 👿 M 2 🗆 F Days 579-76-1311 WASHINGTON, DC Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No PRINCE GEORGE'S CAPITOL HEIGHTS MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ò must be 23a Funeral USA 20743 4207 RAIL STREET 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. , or P 1 Never Married 2 X Married Completed by Yes 2 No POST-BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", 3 Widowed 4 Divorced Year or Dates Jr than "he." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12TH College (1-4 or 5+) Hygiene. GOVERNMENT traumatic event, the DRIVER other Be 18. Mother's Name (First, Middle, Maiden Sumame) pe filed 17. Father's Name (First, Middle, Last) of and 2 should be file of Health and Mental Fitem 27 is marked or ည LUMFORD ELLA HAYWOOD VAUGHN JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i RAIL STREET CAPITOL HEIGHTS, MARYLAND 20743 4207 WANDA R. VAUGHN/WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H Important: If ite any injury or ot Page 1 MD VETERANS CEMETERY 11/1/2011 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 100 m 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final CTPPHOSTS OF THE TANKS) Approximate Onset and Death CIRRHOSIS OF THE LIVER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** HEPATITIS C UNKNOWN ETIOLOGY Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury and -transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events Due to (or as a consequence of): resulting in death) Last burial ending physician ruse as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day ρ 5 Other (specify) 2 No the g Unknown rate nas been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 X Unknown **HUMAN IMMUNODEFICIENCY VIRUS** Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🛣 No 1 Yes 2 No certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, ၉ To the Funeral Director: After this completed filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 1 X Natural 5 Pending Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

within 24 hours a

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

29a. Certifier

(Check

3 29b. Signature and title of certifie

8

KAREN ANN BLACKSTONE, MD, VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

Registrar

A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

OCTOBER 27, 2011

29c. License number

MD# 33255

			Please Type or Print	in Black Indelible Ink Ensure All #31perDVR,G920,10/28/2011,W land / Department of Health and Me	Copies Are Legible.
		-	For State Of Wally State Registrar	Certificate of Death	Reg. No. 2011 34489
A.	Physicia Medic		1. Decedent's Name (First, Middle, Last) Alice Royster	Winbush	Date of Death Month O A A O I I I I I I I I I I I I I I I I
-	Examin			4b. City, Town, or Location of Death Randall ST 12 Y last birthday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Year) 4c. County of Death 9. Birthplace (State or Foreign Country)
	Director 3		215-18-6342 1 M 2 VF Usual Residence of Decedent	90 Yrs. Months Says Teach	-5-1921 Narylana
	Maryland 28a-f show otified at	Director	MD NA	Baltimore	10d. Inside City Limits 1 ☑Yes 2 ☐ No
	with the s 23a or ust be n	Funeral D	1901 Elain Avenue.	#315 21217_	10g. Citizen of What Country?
98	is filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	۵	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	in U.S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	(Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc. Specify: *** Black K
21215-0036	72 hours "nature edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	. 16b. Kind of Business Industry
	led within ? Hygiene. other thar ent, the M	Be Con	Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last)	Certified Nursing Assis	tent Lutheren Hospital irst, Middle, Maiden Surname)
Maryland	ild be filed Mental Hy larked oth atic event	To E	Joseph C. Hawk	ins Lenc	Wallace
	2 shouth and it is it is it it		19a. Informant's Ume/Relationship (Type, Print) (Nicco	19b. Mailing Address (Street and Number or Rural R	oute Number, City or Town, State, Zip Code) Rd. Balton, MD 21215
iore,	Page 1 and 3 nent of Healt ant: If item 2 ary or other		1 Nourial 2 Cremation 3 Removal from State	Ob. Place of Disposition (Name of Dat cemetery, crematory or other place)	e 20c. Location - City or Town, State
Baltimore,	permit. Page Department Important: I any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signa re of Funeral Service Licenses	22 Name and Address of Facility	5 Fureral Home, P.A.
<u>m</u>	99 F # 9	H	23a. Parl 1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not enter the mode of dying, such as cardiac or re	Ave. Bolto, MD 21216 Approximate Interval Between
	mysician/ Medical		Immediate Cause (Final disease or condition routities in doubt)	tive heart Failure	Onset and Death
-	Examiner		Sequentially list conditions b.	nsequence of):	
, C	uted d ansit	Examine	ritary, reading to minimiserate cause. Enter Underlying Cause (Disease or iinjury that initiated events	c war of	
78		I— I	resulting in death) Last Due to (of as a co	nsequence of):	
98760	rtificate ing phys e as the	/Medi	IF FEMALE:	romanoli	
. Box 68760	e de the hed	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
ls, P.O.	v requires that th s been signed by t should be detac	ρ	Part II. Other significant conditions contributing to death but n	ot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown
Division of Vital Records,	sician: The law rec certificate has bee lirector, page 2 sho	Completed			24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
Vital	ysician: lis certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	26. Place of Death (Check of D	nly one) 2
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Divisio	al or Attendi s after death. I Director: A d in by the fu	Certificate:	3 Suicide 6 Could not be	At home, farm, street, factory, office 28	f. Location (Street and Number or Rural Route Number, City or Town, State)
_	To the Hospital or vaithin 24 hours after To the Funeral Directory of the filled in brownian or vaithing the completed filled in brownian or vaithing the fi	Medical	(Check 2 Medical Examiner: On the basis of exam	knowledge, death occured at the time, date and place, and ination and/or investigation, in my opinion, death occurred at th t of my knowledge, death occurred at the time, date and place,	e time, date and place, and due to the cause(s) and manner stated. and due to the cause(s) and manner as stated.
	With With Com		29b. Signature and title of certifier	29c. License number 0 0 0 6 5 3 8 3	29d. Date signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death		
	Sta		Shabbir Choudhy M. Day, Year) OCT 28 32. Registrar's	Signature B. Sall	ייין ניין אייין אייין אייין אייין אייין אייין אייין אייין אייין
	Registr	ar	10-16-10-1	knew B. Jakal	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34490 1 - For State Registrar Certificate of Death . Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last 8:40 AM Physician/ Medical 4c. County of Death or Location of Death 4a. Facility Name (if not institution, give s **Examiner** Himore nnar d 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, If Under (In yrs. last birthday) **Funeral** Min. 28-1921 1 🗆 M 2 🗹 F Director 10d. Inside City Limits Town or Location 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State must be notified at Completed by Funeral Director Bal 1 Yes 2 No MD timore 10g. Citizen of What Country? 10f. Zip Code USA 9 23a marc iral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 Married Yes 1 Yes 2 No Specify: Slac Baltimore, Maryland 21215-0036 If Yes, Give Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exarence. 3 Nidowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DONOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) econdary (0-12) 0014 Be Mather's Name (First, Middle, Mai Father's Name (First, Middle, ည 11:07 per, City or Rural Route Number, City or Town 19b. Mailing 21229 DU City or Town, State 20b. Place of Disposition (Name of od of Disposition or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signal re of Funeral Service License Approximate Interval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Part 1. Enter the dis shock, or heart failu rediate Cause (Final failure. List only one cause on each line. case Immediate Cause Ply ician/ honic disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Examine Due to To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Year Day Month in the past 12 months? been signed by the atter Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 2 No 1 Yes Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24b. 24a. Was an autopsy within 24 hours after death.

To the Funeral Director. After this certificate has sompletely filled in by the funeral director, page 2.8 performe 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 Yes 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Mann of Death injury 1 Natural 5 Pending M Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Pay, Year) d title of certifier 29b. Signature Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

filed (Month, Day, Year)
T 2 8 2011

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arks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:57 PM John 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore NIVERSIT If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, Funeral Sex 1 M 2 □ F Months Days Hours 83 March 26, Boston, MA Director 016-22-1004 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland **Funeral Director** notified 1 Tes 2 X No Maryland Harford Forest Hill ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be filed within 72 hours after death with 123 Theodora Ct. 21050 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than alth and Mental Hygiene. 127 is marked other than or traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Accountant - CPA Accounting American Express 4 Be 18. Mother's Name (First, Middle, Maiden Surname) Thk. 17. Father's Name (First, Middle, Last) မ James White Marrian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. Mr. Paul White (San) 2919 Kathleen Drive, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Menorial Greens Aldino, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey R. 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - 1 3 Newport Drive, Forest Hill, Maryland 21050 Testerran (M01543) 23a. Part 1. In earthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ ntracrania disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, RESTRICTED TO BE WEDGE ENMIN Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 🔲 No JYes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Nes 2 □ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending injury thin 24 hours after death. the Funeral Director: After mpleted filled in by the fun 12:00 PM Investigation 6 Could not be 10 23 2011 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Forest Hill, MDZIO Home 123 Theodorn 1. Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I comple 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		1- For State Certificate Registrar 1. Decedent's Name (First, Middle,Last)	or Death	Reg. I 2. Date of Death	No. 3. Time of Death				
Physicia ledical Exami		Choto Marc. Wilk	inson	Month Da October 23, 2	ay Year 2000 here				
		4a. Facility Name (if not institution, give street end number)	4b. City, Town, or Location of Death		4c. County of Death				
		1120 Ingleside Avenue	Woodlawn	lo B / (B) ii a	Baltimore County				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	-	///////// 9. Birthplace (State or Foreign				
Director		214-06-2597 1 M 2 F 27 Usual Residence of Decedent	Yrs.	HOUL IS	5, 1984 Country) MD				
any		10a. State 10b. County 10c. City, Town or Lo	ocation		10d, Inside City Limit				
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Maryland 28a-f show d at once.	ector	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?				
with the Maryland ms 23a or 28a-f sho be notified at once	Il Dire	8333 Ashwood Kd	20794		USA				
tems 2	uneral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.				
ter dez	щ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify:		specify: White				
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5-0036 iled within 72 Hygiene. d other than	Completed	17. Father's Name (First, Middle, Last)	NSTructi OY	(First, Middle, Maid					
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e, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Madical Examiner must be notified at once		Donna Lee Wilkinson 83		Kd. Je	25Sup MD 20794				
re, M s 1 and 2 of Health If item 2			position (Name of cemetery, r other place)	1 1	Oc. Location - City or Town, State				
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Baltimore, pemit. Pages 1 an Department of He Important: If ite injury or other to		21 Sign r of F reral Service Lice (see	2. Name and Address of Facility	owell.	Funeral H				
Physician	4	25a. Fart I. Enter the disease, of semalifications that caused the death. Do not ent	er the mode of dying, such as cardiac o		shock, or heart Approximate Interva				
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Narcotic (Morphi	ne) Intoxication		Between Onset and Death				
Examiner		or condition resulting in death) Due to (or as a consequence of):							
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of Vital Records, in Physician: The law require the this certificate has been sineral director, page 2 should the state of	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpat	26 Place of Death (Check		· · · · · · · · · · · · · · · · · · ·				
F Vi	٩	1 Yes 2 No Prospilar 1 Inpatient 2 ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how	sidence 6 Other: Scene				
on on on on on on one of the fune	Ö	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 x No	unknown					
Division tal or Attendi rs after death. al Director: #	ficat	2 Accident Suicide Suicide Suicide Accident Suicide Suic		28f. Location (Stre	et and Number or Rural Route Number, Cit				
Divi	Certification:	4 Homicide determined (Specify) residence		Woodlawn) 1120 Ingleside Ave , Md.				
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or (check only one) 2 Medical Examiner: On the basis of examination and/or investigation.	ocurred at the time, date and place, and	I due to the cause(s) and manner as stated.				
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigant manner stated. 29b. Signature and title of certifier.	29c. License number		9d. Date signed (Month, Day, Year)				
		A A A A A A A A A A A A A A A A A A A	O.C.M.E.		October 24, 2011				
		30. Name and address of person who completed cause of death (Item 23a)							
4			W. Baltimore Street, Baltimo	re, MD 21223					
		31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Regist	rar	OCT 2 8 2011 /2 / A form	/						

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G921 11/01/2011 JH State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ DOLORES 25,2011 Year SCHEER WARREN OCTOBER 11:30A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1916 8. Date of Birth **Funeral** Days Hours 1 □ M 2 🔀 F New Jersey Day, 155-01-2513 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified 28a-f 1 Yes 2 X No MD Frederick Thurmont 10e. Street and Number 10f. Zip Code r must be n 10g. Citizen of What Country? Funeral 7008 Wood Court 21788 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2X No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 □ Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working alth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Mec life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edmund Scheer Matilda Oettinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ent of Health a ht: If item 27 is y or other trai 7008 Wood Court Thurmont, mD 21788 Judith W. Barker/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or once. Final Journey Crematory 10/28/11 Woodbine, MD 4 Donation 5 Other (Specify) of Funeral Service Licenses Signatu 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksvilla MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No page 2 should be detached for Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 1006 2223 address of person who completed cause of death (Item 23a) (Type, Print)

AVERY BOLANIM, 196 TJONIVE, FREDERICE, MD

State Registrar 31. Date filed (Month, Day, Year) - .

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2. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 6,10d,13,18 per inf g926 4-4-12 vt State of Maryland / Department of Health and Mental Hygiene d Items 24a-29a per dr. 2920,10/28/2011dhb For State Registrar Amend Items Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2 2 ay Ira Fitzgerald Whitworth 201[°]Î 12:10 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Thomas More Nursing & Rehab Hyattsville Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 **V** | Months (Month, Day, Year) 1/16/1930 West Indies 579-70-5464 Director 80 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 X No MD Prince Georges Hyattsville 10e Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2003 Hayden Road 20782 U.S.A. "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 X No Specify: Specify: 3 Midowed 4 Divorced Completed Black Year or Dates and 2 should be filed within 72 hours Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Mechanical Engineer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vincent Whitworth Alice Francis Sylvester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2003~{\rm Hayden}~{\rm Road}$, Hyattsville, MD 20782Zena Whitworth/Daughter other Baltimore, If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ᇹ permit. Page 1
Department of
Important: If if
any injury or o 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 05/25/2011 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gitts Registry 21. Signature of Funeral Service licensee 3 7522 Connelley Drive, Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 X No Director: After this certificate has 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 🕱 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 2 💢 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 Tes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral I 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title-License number 29d. Date signed (Menth, Day, Year) DOO 63681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20783 1835 University Blvd., Ste. 208, Hyattsville, Ajit Kurup, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2820 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 19, 3:00 PM October 2011 Jerome Woods Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 822 E. 22nd Street Baltimore If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 213-52-1219 Director 1 🛛 M 2 🗆 F Yrs. Maryland June 6, 1950 61 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sho the Maryland items 23a or 28a-f sho ner must be notified at Director 1 X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA Funeral 21218 822 E. 22nd Street death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ı "natural", or iter ledical Examiner r 11. Marital Status Arroed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) the none disabled unk other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H
If item 27 is marked ot
r other traumatic ever မ Annie Jones Henry Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Dwight Woods/brother 2205 Roslyn Avenue #D203 Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5 X Other (Specify) 4 Donation icensee Ad ²² State Anatomy Board 655 W. Baltimore Street Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Adenocarcinoma Physician/ month Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Day Month Year Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Yes 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) Hospital: 1 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Certificate: After injury Matural Natural 5 Pending death. 2 No Accident Investigation filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) d title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

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erson who completed cause of death (Item 23a) (Type, Print)

BVAMC

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Greene St.

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per PHY &19a Per TNF G945 11/22/2013 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death October Physician/ 201^{Year} 16^{bay} 6:30 PM CLARA STEWART WING Medical Clara S. Wing 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring <u>Renaissance Gardens</u> 9. Birthplace (State or Foreign If Under 24 Hrs. Social Security Number If Under 1 Year 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** May 14, Year 929 Days Hours 1 □ M 2 🗓 F New York 82 Director 101-26-9009 Usual Residence of Decedent , or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits traumatic event, the Medical Examiner must be notified at the Maryland Director 1 🗆 Yes 2 🔀 No Silver Spring MD Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe by Funeral with 20904 TISA 3160 Gracefield Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. white Specify: "natural" 3 Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) education teaching 12 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clara Louise Stewart Herbert Charles Wing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Wing/son 7457 Swan Point Way Columbia, MD 27 tem 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🗌 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 X Donation 5 Other (Specify) Funeral Serv ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street rector um Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dementia end stage Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Year 4 Pregnant
9 Unknown Month Day Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Crohn's disease, artrial fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 2 No ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: ဥ 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Iniury at s after death. Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending 2 No Investigation Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital of 24 hours at Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 29c. License number 19 15866

State Registrar 30. Name and address of pe

who completed cause of death (Item 23a) (Type, Print)

11-08019 James Leslie Wise Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Leslie Wis		I- For State Registrar	State of Mary		epartment d C <i>ertificate d</i>		and Mental		eg. No. 201	3449
Physiciar Medical Examin	1/	Decedent's Name (First, Minus James Lesli			-			2. Date of Dea Month October 2	Day Year	3. Time of Death 1954 hrs
and the same of th		4a. Facility Name (if not institu	tion, give street and r	number)			, or Location of De		4c. County of Death	
Funeral	٩	Upper Chesapeake 5. Social Security Number	6. Sex	7. Age (In y	yrs. last birthday)	Bel Air	Year If Under 24	Hrs. 8. Date of Bir	rth(MM/DD/YYYY) 9. Bir	
Director		220-54-5432	1 XM 2 F		52 yr		Days Hours	Dec.	24, 1958 Foreig	untry) Maryland
yas	F	Usual Residence of Decedent 10a. State 10b. Count		10c.	City, Town or Loca	ation				10d. Inside City Limits
≱	ام	Maryland Harf	ord		Bel Air					1 Yes 2 No
Maryll	DIFECTOR	10e. Street and Number	: 65 Tama		-	10f. Zip Cod		1	0g. Citizen of What Cou	ntry?
death with the Maryland or items 23a or 28a-f sho must be notified at once.	교 교	307 Briarcl 11. Mantal Status	12. Was De	ecedent Ever			Hispanic Origin?	(Specify Yes or No		can Indian, Black,
r death or iten	runeral	1 Never Married 2	1 Yes	Forces?		3dF	ban, Mexican, Pue	erto Rican, etc.)	White, etc.	hite
nurs afte	함	3 Widowed 4 0 15. Decedent's Education (S	Divorced If Yes, Give Your Dates: pecify only highest gr			nt's Usual Occi	upation (Give kind		16b. Kind of Business/	
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5-00% ed withi lygiene. other th	Completed	17. Father's Name (First, Midd	le, Last)	2	Sales	& Design	n Execut	CLVE ame (First, Middle, I	I	Initure
21215-0036 Juld be filed within 7 IMental Hygiene Imarked other than ic event, the Medica	g n	Leslie (nmn) 19a. Informant's Name/Relatio			10h Mailir	na Address (S			ine Kunkel mber, City or Town, State	Zin Code)
MD 2 id 2 shoulth and M m 27 is m	2	Maureen D.		fe				, Bel Air	, Maryland	21014
Baltimore, MD 21215-0036 Seemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiew in Department of Health and Mental Hygiew do there than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 Cremat	ion 3 Removal		20b. Place of Dispo crematory or o	ther place)		Date	20c. Location - City or	
Baltimore, permit. Pages I an Department of Hea Important: If ites njury or other tr	٩	4 Donation 5 Other 21 Scrature of Funeral Septi	Specify:	\cap	Hilltop	Service Name and Add	e Corp 1 ()-28-2011 McComas	Towson, M Funeral Hom	aryland e.P.A.
Basem Perm Deperming Indian	1	CHELLINI	(Domas	12	1	1317 Col	kesbury I	Road, Abi	ngdon, Mary	land 21009
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Examiner		Immediate Cause (Final disea or condition resulting in death		a consequer		OXICIC				
		Sequentially list conditions, if any, leading to immediate		a ecnsequer	ee of):					
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Box 6876 c death certificate the attending phy ed for use as the b	= I	23b. Was decedent pregnant in past 12 months?	I I LIVE	birth gnant at time	of dooth	etal death	3 Ectopic pre	gnancy	Month I	Day Year
BO) he death	ruysici	1 Yes 2 No 9 L	Jnknown 9 Unk		not resulting in the	underlying cau	se given in Part I	23e Did to	obacco use contribute to	the cause of death?
Division of Vital Records, P.O. Is or Attending Physician: The law requires that the all predictors. After this certificate has been signed by ted in by the funeral director, page 2 should be detach	≥	Fait II. Other Significant Con	adding Contributing	to death but i	nocressating in the	didonying odd			s 2 No 3 Prol	
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n of ding Ph	- r	27. Manner of Death	(Mon	e of Injury th, Day,Year)	28b. Time of	- 4	Injury at Work?		how injury occurred ingested	
Vision or Attent filer death Director: in by the	Certification:	2 X Accident In	vestigation		11 fd 6:3 At home, farm, stre	9 pm		Pseudoe	phedrine Street and Number of Ru State) 307 Bria	ıral Route Number, City
Divisior Hospital or Attend 2 Hours after death Puneral Director: stely filled in by the		4 Homicide	termined (Specifi	y) re	esidence			Bel Air	r,Md.	CIIII bii.
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the L	Medical		xaminer:On the basis	s of examinati					se(s) and manner as stat and place, and due to the	
F. iv. S. io	Ξ -	29b. Signature and title of cert	and manner	stated.			ense number		29d. Date signed (Mo	
		30. Name and address of pers	on who completed as	Use of death	(Item 23a)	0.	C.M.E.		October 26, 201	
\emptyset		Russell Alexander	D. Assistant	Medical E	xaminer 900	W. Baltimo	ore Street, Ba	Itimore, MD 21	223	
Sta Registra		30CT 2017	1) Lener 32. 1	Registrar's Sig	greture College			0	CME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 34498 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wilfong, Jr. 01den 4:43 P M October 19, 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 403 East Thomas Street Union Bridge Carrol1 Co. Social Security Number 6 Sex If Under 1 Year If Under 24 Hr **Funeral** . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 236-14-2638 **Director** 1X M 2 D F 92 March 1,1919 West Virginia Usual Residence of Decedent 28a-f show 10b. County with the Maryland at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits notified 1 Yes 2X No MD Carrol1 Union Bridge 5 10e. Street and Number items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 403 East Thomas Street 21791 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 XYes 2 No
If Yes, Give Black. White, etc. 'natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 ▼ Widowed 4 □ Divorced Year or Dates. WWII White J Hygler ... d other than "nature..." 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Years Material Handler Crown Cork & Seal Co. 7 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ည Olden Wilfong, Sr. Tiny Belle Bennett Page 1 and 2 should ment of Health and M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 East Thomas Street Union Bridge, MD 21791 Mr. Michael Wilfong (Son) 27 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Holly Hill Mem. Gdns. 10/24/2011 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee Signat 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease shock, or head failure. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re-tist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ D ON ANCE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?

1 Yes 2 No
9 Unknown Month Day Year detached 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital 1 Yes 2 X No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 🗐 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 🕅 Natural injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0036616 04 30. Name and address of person who con leted cause of death (Item 23a) (Type, Print) 21702 Thomas JOHNSON 31. Date filed (Month, Day, OCT 2 Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First Middle, Last) 2. Date of Death Physician/ WILLIAMS ブガ 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 315 Marie Avenue Glen Burnie Anne Arundel 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Country) Maryland 1 🗆 M 2 🖊 F Months 05/16/1925 213 22 2412 86 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits the Maryland Director notified Glen Burnie 28a-f Maryland Anne Arundel 1 Yes 2 X No 10f. Zip Code 5 10e, Street and Number 10g. Citizen of What Country? ms 23a or must be Funeral U.S. 315 Marie Avenue 21060 ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ Yes 2 X No 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. if item 27 is marked other than "natural", or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Motor Vehicle Adm. Tag Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Trott Mary Arata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 - 2nd Avenue S.E. Glen Burnie, Maryland 21061 Carol George / Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date jo cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stat Glen Haven Mem. Park 10/28/2011 Department of Important; If any injury or once, Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway come roncello 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final /sicianچىدى disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year ☐ Pregnant at time of death☐ Unknown the Funeral Director: After this certificate has been signed by the related filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 2 Accident 5 Pending work? 1 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the I Certifying Nurse Practioner: To the best of my ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier မ oher 2 62011

Registrar

DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State	of Marylan		rtment tificate				giene	2011	34500	
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О	Examin		4a. Facility Name (If not institution,						cation of Death			Baltin		
			Genesis Multin	edical Le	7. Age (In yrs.	last hirthday)	If Under 1		Mury) Under 24 Ars.	8 Date of Birt				
	Funeral Director		5. Social Security Number 220-20-4765	1 ☐ M 2 🔼 F	83	Yrs.			lours Min.	8. Date of Birt (Month, Da Aug • 2	2, Year 19	928 Mar	nplace (State or Foreign intry) y Land	
			Usual Residence of Decedent										10d. Inside City Limits	
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	28a-f	Director	MD. Baltime	ore	10%	75011	10f. Zip (Code			10a. Citiz	zen of What Co	untry?	
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Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show atto event, the Medical Evanirer must be notified at	Be C	17. Father's Name (First, Middle, L	Ť				18	. Mother's Name			Sumame)		
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enones.		21. Signature of uneral Service L	4 _ //		-			Towson F York Rd.	uneral Towsor	Home , MD	Inc. 21204	+	
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	/Medical		resulting in death)	the same of the same of	(or as a consec	quence of):							7	
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Records,	ie law requ has been ge 2 should	Completed by	Dementia							24a. Was	psy	prior to	utopsy findings available completion of cause of	
	Th afe pag	Con	Winary Incenti	nence	History	of win	ary tra	Stinfe	etion	perf 1 ☐ Yes	ormed? 28 No	death? 1 ☐ Yes	2 □ No	
Vita	iclan: Th certificate rector, pag	Be	25. Was case r ferred to medical examiner?	Hospital:				Othor	6. Place of Dea			. 50::	- 7 \	
ot	Attending Physician: r death. ector: After this certifici by the funeral director,	. To	1 Yes 2 No	28a. Date	of injury	28b. Time o		8c. Injury at Work?	42 Mitaling In	ome 5 ☐ Res 28d. Describe			ocity)	
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the Examiner: On the and ma	ne best of my kn basis of examina nner stated.	owtedge, deat ation and/or in	h occurred vestigation,	at the time, in my opini	date and place, ion, death occur	, and due to the rred at the time	cause(s) , date and) and manner a d place, and du	s stated. e to the cause(s)	
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	0,		30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type,	Print)	171 h V.	المدد الأملام	Thurs	Ma	ruland	2/2/4	
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	Registi	ar	29b. Signature and title of certifier Michelle C. K 30. Name and address of person of the lie E. Kulend 31. Date filed (Month, Day, Year) OCT 28	2011 De	eur 1	a. Aga								